Medical Records Obtained by Authorization

From UTMB - Galveston

301 University Blvd.

Galveston, TX 77555

Pertaining to Raymond Luther Allen

For Anthony G. Buzbee

Nell McCallum & Associates, Inc.

19092.001

THE UNIVERSITY OF TEXAS MEDICAL BRANCH GALVESTON TEXAS

AFFIDAVIT

PATIENT'S NAME: Raymond Allen

UNIT HISTORY NUMBER: 334674P

*Before me the undersigned authority, personally appeared **Dana Jones**, who being by duly sworn affirms that the facts stated herein are true and correct.*

*My name is **Dana Jones**, I am of sound mind, capable of making this affidavit and personally acquainted with the facts herein stated.*

*I am the custodian of the records of the University of Texas Medical Branch Hospitals. Attached hereto **240** pages and/or **0** diazo copies of records of the University of Texas Medical Branch Hospitals. These said **240** pages and/or **0** diazo copies of records are kept by the University of Texas Medical Hospitals in the regular course of business, and it was the regular course of business of The University of Texas Medical Branch Hospitals for an employee or representative of The University of Texas Medical Branch Hospitals, with knowledge of the act, event, condition, opinion, or diagnosis recorded, to make the record or to transmit information thereof to be included in such record, and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are the original or exact duplicates of the original.*

Affiant

*SWORN TO AND SUBSCRIBED before me on the **1st** of **May 2012.***

TAEANA-RENAE TAITANO SAGPAO
MY COMMISSION EXPIRES
March 9, 2013

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

I, Laura Beth Hataway, a Notary Public in and for the State of Texas, do hereby certify that the foregoing Testimony of the Witness, Dona Jones, after said witness was duly sworn by Taeana-Renae Taitano Sagpao was delivered to Nell McCallum & Associates, Inc.

I further certify that said Original Answers are being delivered to Anthony G. Buzbee, the requesting attorney, for safekeeping and use at trial.

Given under my hand and seal of office on May 14, 2012.

Laura Beth Hataway
Notary Public

Nell McCallum & Associates, Inc.
Beaumont/Houston, Texas

19092.001

Nell McCallum & Associates, Inc.

has verified that these records are complete

and the best possible quality

01

THE UNIVERSITY OF TEXAS MEDICAL BRANCH
GALVESTON, TEXAS 77555

MEMORANDUM

To: Record Processing – Lucy Moreno
Trauma Service – Dianna Grimm-Mapp
Patient Finance/Coding- Raylene Morgan, Lora Hofer, Jacqueline Brooks, Janice Green, Daniel Coronado
HIM/Offsite- Joe Aguilar
Radiology-Belinda Escamilla, Maria Solis, Anna Perez, Brenda Guidry, Brenda Ross, Cynthia Lucia, Cheryl Johnson

From: Department of Health Information Management

Re: Change of Unit History Number

Date: March 2, 2012

The Department of Health Information Management has discovered an incorrect Unit History Number. Please update your records or computer programs to reflect the following correct information:

Patient's Name: ALLEN, RAYMOND LUTHER Aka: FEBTWELVE, FOX

Incorrect UH#: 346705-N

Correct UH#: 334674-P

Admission Date: 2/2712 **Discharge Date:** 02/29/12

Case#: 30001643128

Thank you for your cooperation in this matter.

Thanks: Blanca Elizalde 409-772-1744
j:share/mpi/memorandum

02

CODE STATUS

FEBTWELVE,FOX

346705N 30001643128 02/27/1974 38Y M

DOCTOR UNASSIGNED,

Q/ /I

MPUMICU
J4B J4B 02 / 24203

NOT VALID UNTIL SIGNED

UTMB: MEDICAL RECORD COPY
HOSPITALS AND CLINICS

52557044/52557045

ADMIT: 2/27/12 1649 ATTENDING: 0008343 GULSHAN SHARMA, MD 203341
OUTPT BED: 2/27/12 1154 *RESIDENT *: 0010382 IJEOMA C NWELUE, MD 235780
HOSPITAL DX:
ALLERGIES: none
HEIGHT: 178 cm WEIGHT: 100 kg (actual) 02/27/12 BSA: 2.22 (m^2)

PROCEDURE: CODE STATUS: DO NOT RESUSCITATE / FULL INTERVENTIONS
START: 2/28/2012 0145 END: Until Specified
PRIORITY: Routine
FREQUENCY: SEE-COMMENTS
SUMMARY: SEE-COMMENTS starting 2/28/2012 0145 Until Specified, Routine.
ORDERED BY: MCCRACKEN MD, JENNIFER L (2/28/12 0136)
ORDERED BY: #0010454 MCCRACKEN, JENNIFER L, MD 235382

No Questions

Comments Part A: Patient has no pulse and is not breathing - Do Not Resuscitate (DNR)

Part B: Patient has pulse and/or is breathing -Full Interventions:

Oral and body hygiene, offer food and fluids orally as tolerated, medication, positioning, wound care, warmth, appropriate lighting and other measures to relieve pain and suffering, privacy and respect for the dignity and humanity of the patient, oxygen, suction, treatment of airway obstruction by positioning, oral/nasal airway, non-invasive ventilation, non-invasive monitoring, medication, IV fluids, invasive monitoring, intubation, and defibrillation as indicated.

Part C: Other Instructions: None.

Decision reached by: Patient without decision making capacity, Deciding Family Member (Includes parents making the decision for minor child) / Relation/Name: Wife,

Attending Faculty Signature — Date 2/28/12

Resident Signature — Date 2-28-12

03

CAUTION

THIS PATIENT IS KNOWN TO HAVE A SENSITIVITY TO THE ITEMS LISTED BELOW

	Agent	Reaction	Signature	Date	Time
1.	NKA	—	[signature] RN	2/27/12	2300
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND URN IN SPACE BELOW

RECORD OF SENSITIVITY

02/27/12 11:54
346705 M 3M 02-27-74
FESTWELVE ,FOX
3090165431

022712

Medical Record Form 5001-Rev. 03/10
The University of Texas Medical Branch Hospitals
Galveston, Texas

The Medical Record

3

04

DISPOSITION OF VALUABLES

UTMB Hospitals will not assume responsibility for lost or damaged valuables, clothing or personal items kept in the patient's possession. Valuable may be deposited in the Cashier's Office for safekeeping upon patient/family request or identified need.

Comments

0 Valuables Present

Signature of Hospital Representative explaining policy

(IHOP Policy 9.1.2 Management of Patient Belongings)

RN

Date 1/28/12 Time 0005

Patient or Family representative signature

Date 01/28/12 Time 0005

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

02/27/12 11.54
3467054 N 8M 02-27-74
FEBTWELVE ,FOX
37001-43129

YY 022712

DISPOSITION OF VALUABLES

Medical Record Form 5090-104-Rev. 10/07
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

Patient Health Care Concern ☐ Actual ☐ Potential	Initiated Date	Time	Initials	Resolved Date	Time	Initials
Alterations in respiratory function	2-27-12	2025	SC			

Patient Goal/Measurable Outcome	Identified Date	Time	Initials
1. Maintain acceptable SpO2/ blood gas levels	2-27-12	2025	SC
2. Maintain acceptable respiratory rate/ breathing pattern	2-27-12	2025	SC
3.			

Plan of Action	Initiated Date	Time	Initials	Completed or D/Cd Date	Time	Initials
1 Oxygen therapy	2-27-12	2025	SC	2/29/12	1520	MT
2 CPAP/BiPAP						
3 Conventional mechanical ventilation	2-27-12	2025	SC	2/29/12	1520	MT
4 Pulmonary Mechanics	2-27-12	2025	SC	2/29/12	1520	MT
5 Assess/ suction patient as needed	2-27-12	2025	SC	2/29/12	1520	MT
6 Wean as tolerated	2-27-12	2025	SC	2/29/12	1520	MT
7 Arterial Blood Gases	2-27-12	2025	SC	2/29/12	1520	MT

Patient Health Care Concern ☐ Actual ☐ Potential	Initiated Date	Time	Initials	Resolved Date	Time	Initials
Concern for Atelectasis/Airway Clearance	2-27-12	2025	SC			

Patient Goal/Measurable Outcome	Identified Date	Time	Initials
1. Decreased Sputum Production	2-27-12	2025	SC
2. Improve Cough Effectiveness	2-27-12	2025	SC
3. Improve Breath Sounds	2-27-12	2025	SC

Plan of Action	Initiated Date	Time	Initials	Completed or D/C Date	Time	Initials
1 Cough and Deep Breathe						
2 Incentive Spirometer						
3 PEP Therapy/IPPB Therapy						
4 Chest Percussion/Postural Drainage						
5 IPV/Vest Therapy						
6 NTS/Suction						
7						
8						

Initials	Signature	Initials	Signature	Initials	Signature
SC					
MT	Respiratory RRT				

Reviewed Date	Time	Initials	Reviewed Date	Time	Initials	Reviewed Date	Time	Initials

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIN SPACE BELOW

346705N 02/27/12 11:54
FEBTWELVE, FOX 3M 02-27-74
3000164312

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

022912

06

Patient Health Care Concern	☒ Actual ☐ Potential	Initiated Date	Time	Initials	Resolved Date	Time	Initials
Alterations in respiratory function		2-27-12	1210				

Patient Goal/Measurable Outcome	Identified Date	Time	Initials
1. Maintain acceptable SpO2/ blood gas levels	2-27-12	1200	
2. Maintain acceptable respiratory rate/ breathing pattern	2-27-12	1200	
3.			

Plan of Action	Initiated Date	Time	Initials	Completed or D/Cd Date	Time	Initials
1 Oxygen therapy	2-27-12	1200		3/29/12	1520	
2 CPAP/BIPAP						
3 Conventional mechanical ventilation	2-27-12	1200		3/29/12	1520	
4 Pulmonary Mechanics	2-27-12	1200		3/29/12	1520	
5 Assess/ suction patient as needed	2-27-12	1200		3/29/12	1520	
6 Wean as tolerated	2-27-12	1200		3/29/12	1520	
7 Arterial Blood Gases	2-27-12	1200		3/29/12	1520	

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated Date	Time	Initials	Resolved Date	Time	Initials
Concern for Atelectasis/Airway Clearance							

Patient Goal/Measurable Outcome	Identified Date	Time	Initials
1. Decreased Sputum Production			
2. Improve Cough Effectiveness			
3. Improve Breath Sounds			

Plan of Action	Initiated Date	Time	Initials	Completed or D/C Date	Time	Initials
1 Cough and Deep Breathe						
2 Incentive Spirometer						
3 PEP Therapy/IPPB Therapy						
4 Chest Percussion/Postural Drainage						
5 IPV/Vest Therapy						
6 NTS/Suction						
7						
8						

Initials	Signature	Initials	Signature	Initials	Signature

Reviewed Date	Time	Initials	Reviewed Date	Time	Initials	Reviewed Date	Time	Initials

30001643128 346705N

FEBTWELVE ,FOX

02/27/1974 B M

STAT LABL

E

02/27/12R 11.54 HSU-FRT

AREA IN SPACE BELOW

Interdisciplinary Plan of Care

Medical Record Form Number 3091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

07

Primary Diagnosis / Problem: Cardia Arrest / Shock
Additional Problems (list below)
1. Shock
2.
3.
4.

Patient Health Care Concern	☐ Actual ☒ Potential	Initiated			Resolved		
		Date	Time	Initials	Date	Time	Initials
Knowledge deficit R/T diagnoses, treatment and hospitalization		2/27/12	23:00	TJ			

Patient Goal/Measurable Outcome	Identified		
	Date	Time	Initials
1. Patient/family will be able to verbalize understanding of diagnosis and treatment	2/27/12	23:00	TJ
2.Patient/family will be able to identify causes of exacerbation of disease			

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Orient to room, monitor routine and purpose for admission	2/27/12	23:00	TJ			
2 Provide Fact Sheets, booklets, videos and verbal instructions as indicated	2/27/12	23:00	TJ			
3 Evaluate understanding of instructions and teaching	2/27/12	23:00	TJ			
4 Involve family in plan of care whenever possible	2/27/12	23:00	TJ			
5 Teach/reinforce teaching of exacerbation causes when applicable	2/27/12	23:00	TJ			

Patient Health Care Concern	☐ Actual ☒ Potential	Initiated			Resolved		
		Date	Time	Initials	Date	Time	Initials
Alteration in comfort R/T pain		2/27/12	23:00	TJ			

Patient Goal/Measurable Outcome	Identified		
	Date	Time	Initials
1. Pt will understand & utilize a 1-10 scale method of quantifying pain			
2. Pt will understand the nature of pain and its management with analgesics			
3. Pt will set a comfort goal of 3/10 or be pain free	2/27/12	23:00	TJ

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Educate pt on pain scale						
2 Assess and document effectiveness of pain relief measures utilized	2/27/12	23:00				
3 Utilize non-pharmacologic methods for pain relief (i.e. repositioning, diversion)						
4 Discuss the effectiveness of pain management with physician	2/27/12	23:00				
5 Evaluate unconscious or intubated patients for non-verbal expressions of pain	2/27/12	23:00				
6 Identify and discuss pain relief goals with the patient and family	2/27/12	23:00				

Initials	Signature	Initials	Signature	Initials	Signature
TJC	TJ Cullen	SK	Sharon Kuhlman		
BJM	Brandi Mendoza				

Reviewed			Reviewed			Reviewed		
Date	Time	Initials	Date	Time	Initials	Date	Time	Initials
2/27/12	23:00	TJ						
2/28/12	0800	BJM						
2/28/12	1100	TJ						
2/29/12	0800	TJ						

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIT IN SPACE BELOW

02/27/12 11:5?
3467054 SM 02-27-74
FEATHELVE ,JOY
30001-431

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

Patient Health Care Concern	☑ Actual ☐ Potential	Initiated			Resolved		
		Date	Time	Initials	Date	Time	Initials
Alteration in skin integrity R/T ☐Pressure ☑Immobility ☐Incontinence ☐Malnutrition ☐ Friction		9/7/12	1300	TH		08	

Patient Goal/Measurable Outcome	Identified		
	Date	Time	Initials
1. Pt will have no skin breakdown	9/7/12	1300	
2. Pt will have no further breakdown in pre-existing			

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Assess skin upon admission then Q shift & PRN	9/7/12	1300	TH			
2 Reposition Q 2 hrs and PRN with pillows & wedges as appropriate						
3 Perform risk assessment per unit standard	9/7/12	1300	TH			
4 Monitor I & O and nutritional intake	9/7/12	1300	TH			
5 Avoid pressure from cables, a-lines, foley, tubings, etc.	9/7/12	1300	TH			
6 Use team lift when turning or repositioning patient	9/7/12	1300	TH			
7 Promote mobility as appropriate (i.e. out of bed to chair, ambulation)						
8 Consult skin specialist as appropriate	9/7/12	1300	TH			

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated			Resolved		
		Date	Time	Initials	Date	Time	Initials
Alteration in Nutrition Status							

Patient Goal/Measurable Outcome	Identified	
	Date	Time
1. Patient/family will verbalize understanding of nutritional deficit		
2.Patient will have optimal nutritional status		
3.Patient will receive adequate caloric intake		

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Assess patient's nutritional status on admission and PRN						
2 Monitor weights daily, strict I & O, monitor lab values						
3 Assess ability to chew and swallow						
4 Encourage family involvement						
5 Monitor position of comfort for meals						
6 Nutrition consults PRN						
7 Offer nutrition supplements as ordered						
8 Maintain / monitor diet intake and/or calorie count						

Initials	Signature	Initials	Signature	Initials	Signature
TH	[illegible]				

Reviewed			Reviewed			Reviewed		
Date	Time	Initials	Date	Time	Initials	Date	Time	Initials
9/7/12	0100	TH						

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIT IN SPACE BELOW

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

09

Patient Health Care Concern	☐ Actual ☑ Potential	Initiated			Resolved		
Alteration in fluid volume status ☑ Deficit (hypovolemia) ☐ Excess (hypervolemia)		Date	Time	Initials	Date	Time	Initials
		2/27/12	23:00	TH			

Patient Goal/Measurable Outcome	Identified		
1. Patient will have adequate fluid volume status	Date	Time	Initials
	2/27/12	23:00	TH

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Administer fluids as ordered	2/27/12	23:00	TH			
2 Maintain strict I & O's	2/27/12	23:00	TH			
3 Document daily weights	2/27/12	23:00	TH			
4 Assess skin turgor and mucous membranes	2/27/12	23:00	TH			
5 Monitor VS and lab values	2/27/12	23:00	TH			
6 Monitor mental status	2/27/12	23:00	TH			
7 Administer diuretics and/or inotropes as ordered	2/27/12	23:00	TH			
8 Restrict fluids as ordered	2/27/12	23:00	TH			
9 Educate patient/family on dietary considerations	2/27/12	23:00	TH			

Patient Health Care Concern	☐ Actual ☑ Potential	Initiated			Resolved		
Infection		Date	Time	Initials	Date	Time	Initials
		2/27/12	23:00	TH			

Patient Goal/Measurable Outcome	Identified		
1. Patient will be free of signs and symptoms of infection	Date	Time	Initials
2.Patient will verbalize understanding of cause of infection			
3.	2/23/12	23:00	TH

Plan of Action	Initiated			Completed or D/C'd		
	Date	Time	Initials	Date	Time	Initials
1 Follow universal precautions	2/27/12	23:00	TH			
2 Assess for infection or risk for infection	2/27/12	23:00	TH			
3 Follow isolation requirements as per Epidemiology standards	2/27/12	23:00	TH			
4 Wash hands before and after patient contact	2/27/12	23:00	TH			
5 Monitor vital signs and notify MD of abnormal parameters	2/27/12	23:00	TH			
6 Monitor lab results	2/27/12	23:00	TH			
7 Administer antibiotics as ordered	2/27/12	23:00	TH			
8						

Initials	Signature	Initials	Signature	Initials	Signature
				TH	

Reviewed			Reviewed			Reviewed		
Date	Time	Initials	Date	Time	Initials	Date	Time	Initials
						2/28/12	0600	TH

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIT IN SPACE BELOW

02/27/12 11:54
346705N 8M 02-27-74
FEBTWELVE, FOX
3090L5+3L

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Impaired gas exchange							

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Patient will have effective ventilation			
2. Patient will have effective oxygenation			
3.			

Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1 Continuous pulse oximetry						
2 Assess breath sounds Q 4 hours, monitor RR and breathing pattern						
3 ABG's as ordered						
4 Suction PRN for airway clearance						
5 HOB ≥ 30 degrees as condition allows						
6						

Patient Health Care Concern	☑ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Care of the patient requiring mechanical ventilation		5/27/12	23:00	TL			

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Patient will maintain effective ventilation and oxygenation	5/27/12	23:00	TL
2. Patient will maintain patent airway	5/27/12	23:00	TL
3. Patient will wean from ventilator / no longer require ventilator support as soon as possible	5/27/12	23:00	TL

Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1 Assess respiratory system Q 4 hours and PRN	5/27/12	23:00	TL			
2 Monitor arterial blood gas as ordered	5/27/12	23:00	TL			
3 Monitor vital signs as ordered with continuous pulse oximetry	5/27/12	23:00	TL			
4 Maintain ventilator settings as ordered	5/27/12	23:00	TL			
5 Monitor peak airway pressure as ordered	5/27/12	23:00	TL			
6 Position head of bed ≥ 30 degrees as condition permits	5/27/12	23:00	TL			
7 Perform oral care per unit standard	5/27/12	23:00	TL			
8 Promote weaning trials as ordered	5/27/12	23:00	TL			
9 Follow sedation/analgesia plan as ordered	5/27/12	23:00	TL			
10 Suction patient PRN						

Initials	Signature	Initials	Signature	Initials	Signature
TL					

Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials
5/28/12	0200	[redacted]						

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UN# IN SPACE BELOW

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

Patient Health Care Concern	☑ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Alteration in mental status		2/27/12	2300	TH			

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Mental status will be maintained or improve	2/27/12	2300	TH
2. Patient will remain free from harm	2/27/12	2300	TH
3.			

Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1 Orient patient as appropriate						
2 Assess mental status every 4 hours and PRN or as ordered	2/27/12	2300	TH			
3 Promote normal sleep pattern						
4 Facilitate conducive environment for rest (i.e. dim lights, decrease stimuli, etc)	2/27/12	2300	TH			
5 Medicate patient as ordered	2/27/12	2300	TH			
6 Encourage visitation as appropriate during awake hours						
7						

Patient Health Care Concern	☐ Actual ☑ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Injury related to Fall		2/27/12	2300	TH			

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Injury prevented; patient will not experience fall during hospitalization	2/27/12	2300	TH
2. Patient/Family will verbalize understanding of fall precautions, risk assessment, and interventions implemented	2/27/12	2300	TH
3. Patient will demonstrate compliance with fall precautions			

Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1 Perform fall risk assessment upon admission and every shift per protocol	2/27/12	2300	TH			
2 Implement fall risk interventions per protocol	2/27/12	2300	TH			
3 Instruct patient on fall risk findings and interventions implemented	2/27/12	2300	TH			
4 Teach / Reinforce fall prevention and interventions – include family	2/27/12	2300	TH			
5 Bed in low position, call light within reach, bed locked, siderails up	2/27/12	2300	TH			
6 Monitor patient activities closely to promote safety	2/27/12	2300	TH			
7 Instruct patient to call for assistance before attempting to get out of bed						
8						

Initials	Signature	Initials	Signature	Initials	Signature
TH					

Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials
2/27/12	2300	TH						

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIT IN SPACE BELOW

02/27/12 11:54
3467054M 3N 02-27-74
FEBTWELVE, FOX
300016431?

Interdisciplinary Plan of Care

Medical Record Form Number 6091-03/2010
The University of Texas Medical Branch Hospitals
Original – Medical Record

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Potential for injury to self or others (Non-behvioral Restraint Use)							

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Avoid injury			
2. Protect dignity			

	Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1	Consider and/or attempt alternatives to restraints						
2	Obtain physician order for restraint						
3	Use least restrictive restraint method						
4	Initiate Non-behavioral flow sheet						
5	If appropriate, notify family of the use of restraints						
6	Instruct patient on behavior required to remove restraints and reinforce						
7	Monitor skin, circulation, and respirations at least every hour						
8	Monitor for increase in ability to cooperate/decrease behaviors every hour						
9	Provide comfort measures at least every 2 hours						
10	Provide fluid and nourishment at least every 2 hours						
11	Provide bathroom privileges at least every 2 hours						
12	Assess for the continued need for restraints at least every 4 hours						
13	Remove restraint with ROM, position change and skin care every 4 hours						

Patient Health Care Concern	☐ Actual ☑ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Potential for injury secondary to deep vein thrombosis		3/27/12	730	TH			

Patient Goal/Measurable Outcome	Identified Date	Identified Time	Identified Initials
1. Patient will not develop a DVT.	3/27/12	730	TH
2. Patient will maintain adequate tissue perfusion in the presence of a DVT.			

	Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/Ced Date	Completed or D/Ced Time	Completed or D/Ced Initials
1	DVT prophylaxis as specified by MD as:( )SCD(✓)Ted hose( ) Heparin( )Lovenox.	3/27/12	730	TH			
2	Assess for s/s of DVT.	3/27/12	730	TH			
3	Assess for adequate tissue perfusion.	3/27/12	730	TH			
4	Discourage positions that might comprimise blood flow (crossed legs etc.).						
5	Educate pt/family on rationale for dvt prophylaxis and to avoid massaging extremities.						

Initials	Signature	Initials	Signature	Initials	Signature
TH	[illegible]				

Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials
3/28/12	0700	TH						

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNIT IN SPACE BELOW

Interdisciplinary Plan of Care

Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Potential for injury secondary to stress ulcer.							

Patient Goal/Measurable Outcome	Identified Date	Identified Time
1.		
2.		

Plan of Action		Initiated Date	Initiated Time	Initiated Initials	Completed or D/C'd Date	Completed or D/C'd Time	Completed or D/C'd Initials
1	The Multidisciplinary Team						
2	has met on 2/29/12.						
3	No further recommendations ✓						
4							
5	referred to						
6							
7							

Patient Health Care Concern	☐ Actual ☐ Potential	Initiated Date	Initiated Time	Initiated Initials	Resolved Date	Resolved Time	Resolved Initials
Valley Cpgs	RT						

Patient Goal/Measurable Outcome	Identified Date	Identified Time
1.		

Plan of Action	Initiated Date	Initiated Time	Initiated Initials	Completed or D/Ced Date	Completed or D/Ced Time	Completed or D/Ced Initials
1						
2						
3						
4						
5						
6						

Initials	Signature	Initials	Signature	Initials	Signature

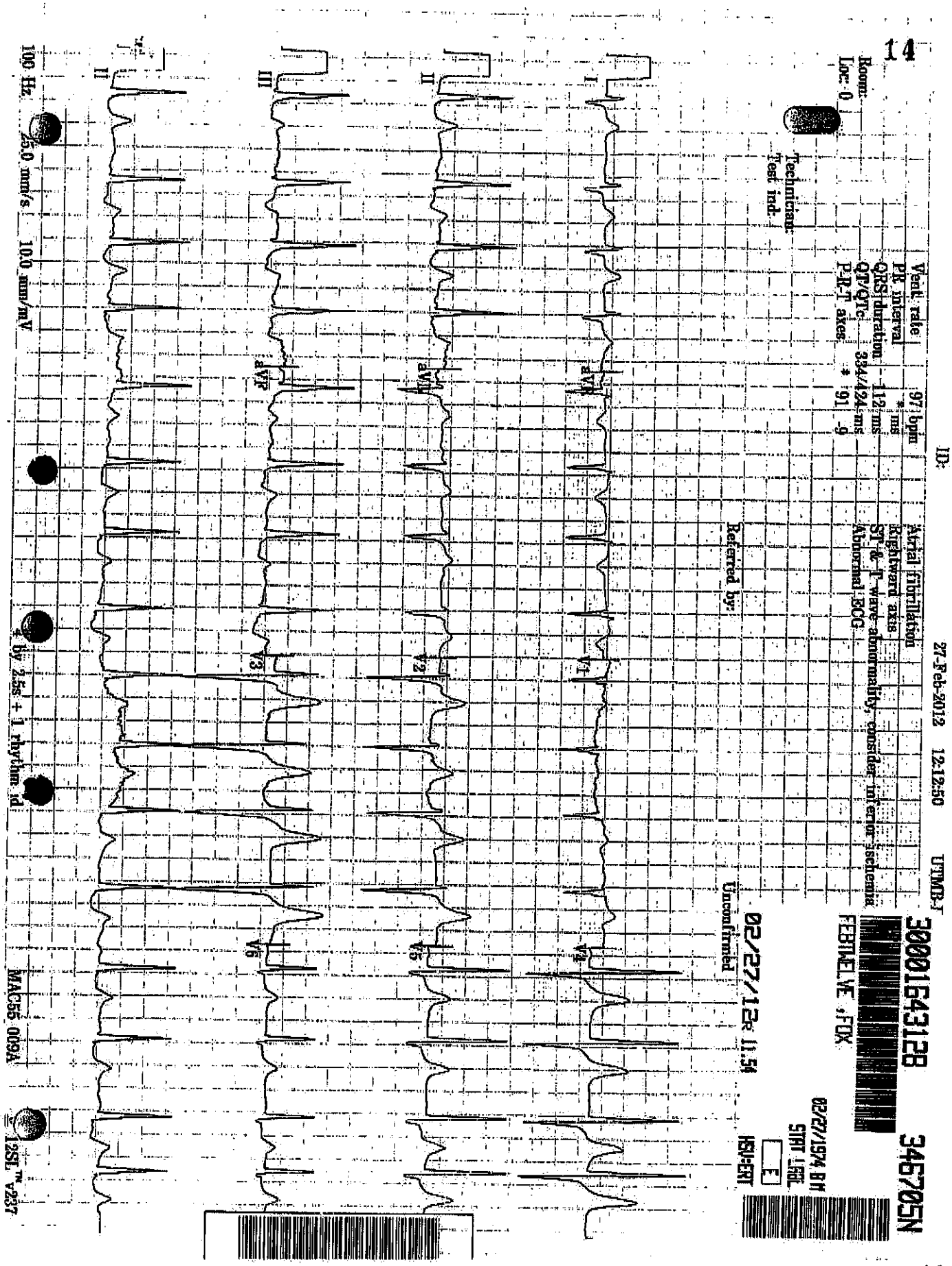
Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials	Reviewed Date	Reviewed Time	Reviewed Initials
2/28/12	1900							
2/29/12	1420							

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE, PT NAME AND UNN IN SPACE BELOW

Interdisciplinary Plan of Care

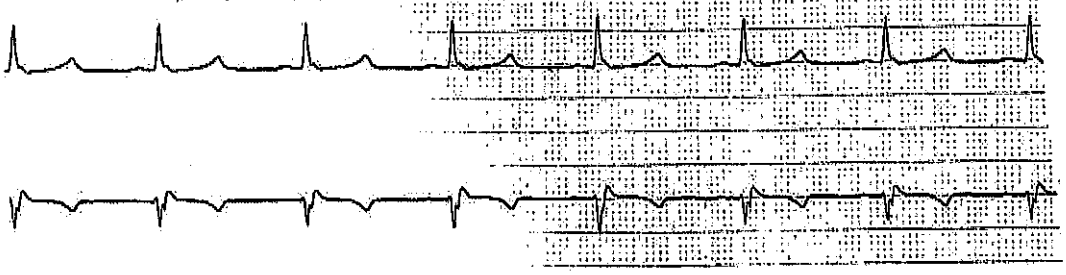
Medical Record Form Number 5091-03/2010
The University of Texas Medical Branch Hospitals

Original – Medical Record


14
Room:
Loc: 0
Technician:
Test ind:
Vent. rate 97 bpm
PR interval * ms
QRS duration 112 ms
QT/QTc 334/424 ms
P-R-T axes * 91 -9
Atrial fibrillation
Rightward axis
ST & T wave abnormality, consider inferior ischemia
Abnormal ECG
Referred by:
Unconfirmed
02/27/12 11:54
FEBTWELVE ,FOX
02/27/1974 0M
STAT LEGL
F
HSV-ERT
3000164312B
346705N
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
100 Hz
25.0 mm/s
10.0 mm/mV
4 by 2.5s + 1 rhythm id
MAC55 009A
12SL ™ v237
ID:
27-Feb-2012 12:12:50
UTMB-J

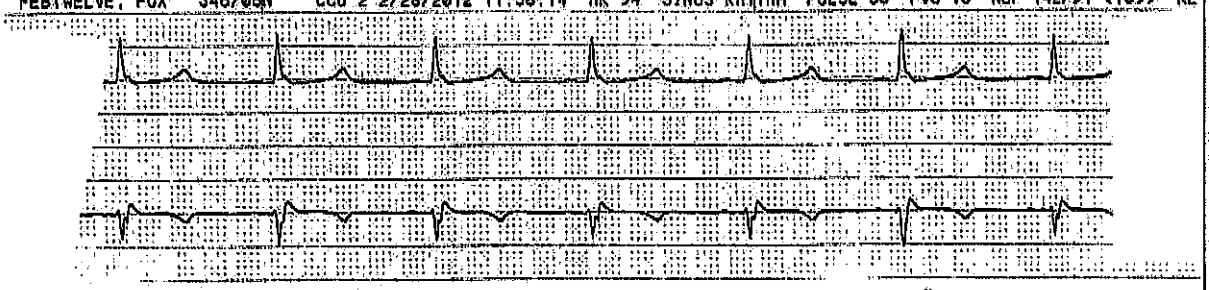
DATE	TIME	LEAD	ARRHYTHMIA DX. & RX BY NURSE 15
			R.N.

FEBTWELVE, FOX 346705N CCU 2 2/28/2012 07:15:35 HR 67 SINUS RHYTHM PAIR PVCs 2 PULSE 64 PVC 4



DATE	TIME	LEAD	ARRHYTHMIA DX. & RX BY NURSE
			R.N.

FEBTWELVE, FOX 346705N CCU 2 2/28/2012 11:58:14 HR 94 SINUS RHYTHM PULSE 63 PVC 13 NBP 142/91 (109) RE



DATE	TIME	LEAD	ARRHYTHMIA DX. & RX BY NURSE
			R.N.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UHP IN SPACE BELOW

02/27/12 11:5*
346705N SM 02-27-74
FEBTWELVE, FOX
3007164312*

ARRHYTHMIA REPORT

Medical Record Form 5433 Rev. 04/10
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

MFG. BY RR Donnelley

UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

Please use the following codes where appropriate:

Learner
P=Patient
F=Family
O=Other*

Learner Preference
V=Verbal
W=Written
D=Demonstration

Readiness to Learn
Y=Yes
*If No, indicate barriers:
PL=Physical Limitations
C=Culture
CL=Cognitive Limitations
D=Desire and motivation
E=Emotional
S=Sight
H=Hearing
L=Language
R=Religious
O=Other*

Method
V=Verbal Instruction
W=Written Material
AV=Audio/Video
C=Class
O=Other*

Language
E=English
S=Spanish
O=Other

Reading Ability
A=Able To Read
D=Difficult To Read
U=Unable To Read

Outcomes
V=Verbalized Understanding
D=Demonstrates Skills
*N=No Evidence of Learning
*NR=Not receptive
*R=Needs reinforcement

*Describe in Narrative Note. (Page 3)

Preferred language for healthcare for the patient or minor patient's parent/guardian _____

Date	Time	Topic/Learning Needs	Place ✓ on Topics Covered	Learner	Readiness to Learn	Learning Preference	Method	Reading Ability	Teaching Language	Outcomes	See Narrative Notes	Signature/Title/Department
		Admission/Initial teaching topics										
2/28/12	0100	Orientation to unit/area	✓	P	Y	L	L	A	E	V		JCarter
		Primary Diagnosis	✓									
		Plan of care	✓									
		Discharge Teaching/plan	✓									
		Medications										MJW
		Admission/Initial teaching topics										
2/29/12	0600	Patient rights and responsibilities	✓	P	Y	V	L/W	A	E	✓		JCarter RN
		Fall Prevention	✓									
		Tobacco Avoidance	✓									
		Pain Management (including scale and comfort goal)	✓									
		Respiratory Management	✓									
		Worsening symptoms	✓									
		How to seek assistance for concerns about the patient's condition	✓									
		Activity and Diet	✓									
		Pressure Ulcer Prevention	✓									
		Medications										MJW
2/27/12	2200	Rationale Ceiling Blanket	✓	F	Y	V	L	A	E	V		JCarter RN
2/27/12	2200	Rationale Foam and Mesh beds	✓	F	Y	V	L	A	E	V		JCarter RN
2/27/12	0215	Rationale Lowered bed	✓	F	Y	V	L	A	E	V		JCarter RN
2/27/12	2200	NPO diet	✓	F	Y	L	L	A	E	V	N	Monica McCall CCA
2/28/12	1200	Reinforced pain management	✓	F	Y	V	V	A	E	R		Monica McCall CCA
2/28/12	1200	Rationale Active Reversing	✓	F	Y	V	V	A	E	V		JCarter MJW
2/28/12	0900	Rationale for Apheresis	✓	F	Y	V	V	A	E	V	-	Family on visit

For additional documentation of physician teaching, please refer to physician progress notes.

INSTRUCTIONS: For preprinted topics document date/time, etc. If not applicable, leave blank. Additional patient/family teaching space is available on page 2. Document resource materials/teaching guidelines and teaching narratives on page 3 (access patient health education resources on the nursing home page). Document reinforced patient education on page 4.

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68006

MFG. BY AR Donnelley

UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UHI# IN SPACE BELOW

346705N 02/27/12 11:5
FEBTWELVE,FOX DM 02-27-74
30001h431P

022712

Interdisciplinary Patient-Family Teaching

Medical Record Form 5635-Rev. 2/11
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

Please use the following codes where appropriate:

17

Learner
P=Patient
F=Family
O=Other*

Learner Preference
V=Verbal
W=Written
D=Demonstration

Readiness to Learn
Y=Yes
*If No, indicate barriers:
PL=Physical Limitations
C=Culture
CL=Cognitive Limitations
D=Desire and motivation
E=Emotional
S=Sight
H=Hearing
L=Language
R=Religious
O=Other*

Method
V=Verbal Instruction
W=Written Material
AV=Audio/Video
C=Class
O=Other*

Language
E=English
S=Spanish
O=Other ____

Reading Ability
A=Able To Read
D=Difficult To Read
U=Unable To Read

Outcomes
V=Verbalized Understanding
D=Demonstrates Skills
*N=No Evidence of Learning
*NR=Not receptive
*R=Needs reinforcement

*Describe in Narrative Note. (Page 3)

Preferred language for healthcare for the patient or minor patient's parent/guardian ____

Date	Time	Topic/Learning Needs	Learner	Readiness to Learn	Learning Preference	Method	Reading Ability	Teaching Language	Outcomes	See Narrative Notes	Signature/Title/Department

For additional documentation of physician teaching, please refer to physician progress notes.

Resource Materials

18

Teaching Guidelines:

List any teaching guides, critical paths, practice guidelines, and other teaching resources utilized.

	Date	Time	Initials			Date	Time	Initials	
1.					4.				
2.					5.				
3.					6.				

Patient/Family Resource Materials:

List any written materials, fact sheets, pamphlets, films, audiotapes, other materials provided to learners.

	Date	Time	Initials			Date	Time	Initials	
1.				How to be an Active Participant in Patient Safety	7.				
2.				Fall Prevention Facts about Fall Prevention or Humpty Dumpty	8.				
3.				Rapid Response Team Information Sheet	9.				
4.	8/8	11a	JD	PT handbook	10.				
5.					11.				
6.					12.				

Narrative Notes/Reference to Other Notes or Forms
Date/Time and Sign Each Entry

8/8 11a JD

Interdisciplinary Patient-Family Teaching – Reinforcement Teaching

Patient-Family Teaching documented on this page represents topics that have been initially documented on page 1 or 2 of this form. These topics have been reinforced with the patient-family.

Reinforced Patient-Family Teaching Topic	Date	Time	Signature	Date	Time	Signature	Date	Time	Signature
P.O.C. Review	2/27/12	2300	[signature]	2/28/12	2000	[signature]			

20

I. [illegible] CONSENT: Knowing that I am suffering from a condition requiring hospital and physician care, I voluntarily consent to such hospital and physician care which includes diagnostic procedures and medical treatment by my physician, his or her assistants, or his or her designees, as may be necessary in his or her judgment. If I receive a psychiatric consultation, anything I say or do may be used in a court proceeding for detention or treatment.

CONSENT FOR TREATMENT IN A HOSPITAL OWNED CLINIC: ***See Reverse Side.***

I understand that I am being admitted to a teaching hospital and, therefore, I may be visited and attended by students or residents of various disciplines.

I acknowledge that no guarantees have been made as to the results of treatment or examination that I will receive.

II. CONSENT FOR NECESSARY TESTS IN THE EVENT OF ACCIDENTAL EXPOSURE TO BLOOD AND/OR BODY FLUIDS: I understand that while I am receiving care, physicians and other health care workers may inadvertently be exposed to my blood and body fluids and that such exposure may potentially transmit infectious diseases including, hepatitis and Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infections. I acknowledge that the law provides for testing of my blood for evidence of these communicable diseases in the event of an accidental exposure and I agree to have my blood drawn and tested if such exposure occurs.

I understand that the tests will be done at the expense of UTMB and will not be charged to my account nor billed to my insurance carrier. I understand that the results of these tests may be released to the affected physician or other health care worker and as otherwise provided in the Communicable Disease Prevention and Control Act.

III. *PERSONAL PROPERTY:* I understand that the hospital provides a safe in the Business Office for the safekeeping of valuables, and that UTMB assumes no responsibility for items that remain in my possession.

IV. *FINANCIAL RESPONSIBILITY:* I hereby promise to pay The University of Texas Medical Branch at Galveston and its Physicians' Billing Service (hereinafter referred to as "UTMB") for any and all services rendered to me as a patient. In addition, I will be financially responsible for my child/children that is/are born or treated here.

If my account is referred to an attorney or collection agency, I agree to pay actual attorneys' fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

V. *MEDICARE PATIENTS:* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf. I have been advised, however, that Medicare may not cover the hospital charges related to this admission. I understand that I will be responsible for all charges should Medicare not pay.

VI. *ASSIGNMENT OF INTEREST IN INSURANCE CLAIMS:* For value received, and in consideration of the hospital and/or physician care and services rendered during the hospitalization and any and all subsequent hospitalization and/or treatment periods, I hereby irrevocably assign, and transfer absolutely to UTMB and/or physicians all my rights, title and interest in medical or disability insurance benefits payable under any plan or policy of insurance and all claims or causes of action relating to my hospitalization, treatments, and physicians' services rendered. I understand that I am responsible for any room rate difference not paid by my insurance company. THIS ASSIGNMENT SHALL NOT BE CONSTRUED AS RELEASING ME FROM HOSPITAL AND/OR PHYSICIANS' BILLS INCURRED, EXCEPT TO THE EXTENT SUCH BILLS MAY BE ACTUALLY COLLECTED UNDER ANY INSURANCE POLICIES OR PLAN.

VII. *ASSIGNMENT OF THIRD PARTY CLAIMS, CRIME VICTIMS COMPENSATION:* I hereby irrevocably assign to UTMB all right, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover. I further authorize UTMB to pursue on my behalf, any claim I may be entitled to pursue before the Crime Victims Compensation Division Of The Texas Industrial Accident Board in the event my hospitalization is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of UTMB. I understand that this agreement in no way restricts my or my dependents' independent rights to pursue any such claim before the Crime Victims Compensation Division Of The Texas Industrial Accident Board in the event I am entitled to file. I understand that if UTMB is not paid in full by proceeds of any insurance policies then this assignment does not release my obligation and liability to UTMB for payment of the services and items provided to me by UTMB. I agree to pay UTMB for all charges incurred or, alternatively, for all charges in excess of the sums actually paid pursuant to said policies.

VIII. *CREDIT EVALUATION:* I hereby authorize UTMB to make necessary investigation of my credit transactions by appropriate inquiry.

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68539

MFG. BY ACCESS UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

[illegible]

AGREEMENTS, AUTHORIZATIONS AND IRREVOCABLE ASSIGNMENTS

Medical Record Form 2001-Rev. 08/03

Department of Admitting
301 University Blvd.
The University of Texas Medical Branch Hospitals
Galveston, Texas 77555-0209
I.R.S. #74-6000949

MEDICAL RECORD

IX. ***CONSENT FOR RELEASE OF PATIENT INFORMATION FOR REIMBURSEMENT AND CONTINUITY OF CARE:*** I authorize UTMB and/or its physicians to release any information (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, including Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus Infection) for the period of my hospitalization to the following: 21

- my insurance carrier(s), the Social Security Administration, its intermediaries or carriers, or any party that is or may be liable for all or part of the hospital and/or physician charges as may be necessary to enable the insurance carrier(s), the Social Security Administration, or any other third party payor to determine the benefits available to me for the services rendered by UTMB;
- individuals, agencies, or facilities, working with UTMB's staff as may be necessary to assist me with discharge planning;
- the Social Security Administration and/or the Texas Rehabilitation Commission, if applicable, for use in determining my eligibility for disability benefits.
- I further authorize UTMB to disclose patient-identifiable information about me for the purposes of seeking reimbursement assistance or for enrolling me in pharmaceutical patient assistance programs that may provide certain products free of charge or at a reduced rate. I understand that, in order to obtain reimbursement assistance or to determine my eligibility to participate in patient assistance programs, certain information about me, including, without limitation, the type and date of my medical diagnosis and treatment, my family income and my health insurance will need to be provided by UTMB to the pharmaceutical manufacturer(s) or their agent(s) for the product(s) prescribed to treat my condition. I understand this information will not be used for any other purposes than that as described above.

I understand that I may withdraw this authorization for release of patient information at any time, but that I must do so in writing.

X. ***CONSENT FOR TREATMENT ON A PSYCHIATRIC UNIT:*** Additional consent is required to be treated on a Psychiatric Unit. Prior to admission I have had reviewed with me in a language that I can understand the following document(s): (Check)
☐ Introductory Statement including access to the patient complaint process and the Adult Patient Bill of Rights.
And if for treatment of a minor: ☐ Adolescent Bill of Rights ☐ Child: Wilbur, the Little Dinosaur Booklet.
And: ☐ UTMB Patient Rights and Responsibilities Statement. **Signature of Patient/Legal Representative X** _____

XI. ***COMPLAINTS ABOUT LICENSEES AND REGISTRANTS OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS:*** I acknowledge that complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attention: Investigations
P.O. Box 2018 • Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353.

XII. A photocopy of this document shall be considered as effective and valid as the original.

XIII. The terms and consequences of this document have been fully explained to me to my understanding, and I have signed it freely and without inducement other than the rendition of services by UTMB and physicians.

The above Agreements, Authorizations, and Irrevocable Assignments pertain to the admission/occasion of service on: 2/27/12

XIV. ***AGREEMENT TO THE ABOVE TERMS AND CONDITIONS:*** My signature below acknowledges that I have read, or have had read to me, the information contained in the paragraphs above, and that I agree to the terms and conditions expressed above.

SIGNATURE X Sabrina Allen RELATION TO PATIENT Spouse

SIGNATURE OF WITNESS Jennifer DATE 2/28/12

XV. ***ACKNOWLEDGMENT OF RECEIPT:*** My signature only acknowledges my receipt of the Message (An Important Message from Medicare) from the Hospital and does not waive any of my rights to request a review or make me liable for any payment.

SIGNATURE _____ RELATION TO PATIENT _____
(Beneficiary or person acting on behalf of beneficiary)

SIGNATURE OF WITNESS _____ DATE _____

XVI. ***AUTHORIZATION TO RELEASE INFORMATION:*** I hereby authorize The University of Texas Medical Branch at Galveston and Physicians' Billing Service (hereinafter referred to as "Hospital") to release any information requested by any insurance company, insurance company designee, self-insured entities, HMO, PPO's, Medicare and/or Medicaid that may be required in order to determine benefits due under the terms of such plan for hospital and physicians' services rendered to the above-named patient.

SIGNATURE X Sabrina Allen RELATION TO PATIENT Spouse
(Beneficiary or person acting on behalf of beneficiary)

SIGNATURE OF WITNESS Jennifer DATE 2/28/12

AGREEMENTS AND AUTHORIZATIONS

22

I. CONSENT FOR DIAGNOSIS AND TREATMENT: Knowing that I am suffering from a condition requiring hospital and physician care, I voluntarily consent to such hospital and physician care which includes diagnostic procedures and medical treatment by my physician, his or her assistants, or his or her designees, as may be necessary in his or her judgment. If I receive a psychiatric consultation, anything I say or do may be used in a court proceeding for detention treatment.

II. CONSENT FOR NECESSARY TESTS IN THE EVENT OF ACCIDENTAL EXPOSURE TO BLOOD AND/OR BODY FLUIDS: I understand that while I am receiving care, physicians and other health care workers may inadvertently be exposed to my blood and body fluids and that such exposure may potentially transmit infectious diseases, including hepatitis and Acquired Immune Deficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infections. I acknowledge that the law provides for testing of my blood for evidence of these communicable diseases in the event of an accidental exposure and I agree to have my blood drawn and tested if such exposure occurs.

III. PERSONAL PROPERTY: I understand that the hospital provides a safe in the Business Office for the safekeeping of valuables, and that UTMB assumes no responsibility for items that remain in my possession.

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☐ Introductory Statement including access to the patient complaint process and the Adult Patient Bill of Rights.
And if for treatment of a minor: ☐ Adolescent Bill of Rights ☐ Child: Wilbur, the Little Dinosaur Booklet.
And: ☐ UTMB Patient Rights and Responsibilities Statement.

Signature of Patient/Legal Representative X _____ Signature of Witness _____

V. COMPLAINTS ABOUT LICENSEES AND REGISTRANTS OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS: I acknowledge that complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attention: Investigations
P.O. Box 2018 Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:
1-800-201-9353

VI. A photocopy of this document shall be considered as effective and valid as the original.

VII. The terms and consequences of this document have been fully explained to me to my understanding, and I have signed it freely and without inducement other than the rendition of services by UTMB and physicians.

VIII. AGREEMENT TO THE ABOVE TERMS AND CONDITIONS: My signature below acknowledges that I have read, or have had read to me, the information contained in the paragraphs above, and that I agree to the terms and conditions expressed above.

SIGNATURE [signature] RELATION TO PATIENT _____

SIGNATURE OF WITNESS [signature] DATE 2/27/12 TIME 1154

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE [illegible] IN SPACE BELOW

30001643128 346705N
FEBTWELVE ,FOX
02/27/1974 B M
STAT LABL
E
HSV:ERT
02/27/12R 11.54

EMERGENCY SERVICES

Agreements and Authorizations

Medical Record Form 2001-101–Rev. 04/10
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original–Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.

SECTION 1: GALVESTON COUNTY MEDICAL EXAMINER JURISDICTION	*To be completed by Physician*

You must notify the Galveston County Medical Examiner (GCME) by calling ext. 24004 if any of the following apply. This applies to all deaths including those of Texas Department of Criminal Justice (TDCJ) and all other incarcerated individuals. If you are unsure if it is a Medical Examiner case, call the Medical Examiner. Check appropriate criteria:

- ☐ A patient dies within 24 hours of hospitalization
- ☐ A patient younger than 6 years of age dies (excluding stillborn)
- ☐ You are uncertain of the circumstances of death
- ☐ You suspect death was by unlawful means
- ☐ Circumstances lead you to suspect the death by suicide
- ☒ Someone dies from unnatural causes, no matter how remote in time **(Verify from prior hospitalizations whether death resulted from an earlier trauma, accident, attempted suicide, near-drowning, poisoning, or burns).**

If the Medical Examiner exercises jurisdiction over the death, complete entire form EXCEPT section 4.

- ☐ None of the above applies. Proceed to section 2.

SECTION 2: TEXAS DEPARTMENT OF CRIMINAL JUSTICE DEATHS	*To be completed by physician*

Is patient a Texas Department of Criminal Justice inmate? Yes (No)

If yes, notify the TDCJ Chaplain's Office, ext. 26191, or TDCJ communications, ext. 26108, and skip to Section 6.

SECTION 3: DETERMINING LEGAL NEXT-OF-KIN (CONSENT HIERARCHY FOR AUTOPSIES AND DISPOSITION OF BODY)	*To be completed by Physician*

A Medical Power of Attorney routinely ceases to be effective upon death. If family conflict arises, or if medical power of attorney contains language regarding disposition, or if a legal guardian exists, or if uncertain about the above, contact Legal Affairs.

Move lower on the list only if unavailable or inapplicable.

- ☐ Decedent's written wishes for disposition of body (not applicable for autopsy)
- ☒ Decedent's spouse
- ☐ Decedent's adult children
- ☐ Decedent's parents
- ☐ Decedent's adult brother or sister
- ☐ The guardian of the person of the decedent at the time of death

Comments regarding status: Wife gives permission to contact father (see below)

IF PT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

02/27/12 11:54
345705N 3M 02-27-74
FEBTWELVE ,FOX
3007454

AUTHORIZATION FOR POST-MORTEM PROCEDURES PAGE 1 OF 3

Medical Record Form 5012-Rev. 7/25/2008

The University of Texas Medical Branch Hospitals Galveston, Texas

022912

SECTION 4: AUTHORIZATION FOR AUTOPSY
IF MEDICOLEGAL SKIP TO SECTION 5.

To be completed by Physician

UTMB offers autopsy for all inpatient deaths. The pronouncing physician is responsible for discussing autopsy with the legal next of kin. They are also responsible for obtaining written consent when the legal next of kin is present and agrees to the procedure. If the legal next of kin can not be contacted, or are not present to sign the consent, send the body to the hospital morgue and Autopsy Services will contact the legal next of kin for consent.

Check one:

- [X] **Discussed autopsy with legal next of kin and procedure declined. Proceed to section 5.**
- [ ] **Legal next of kin requests autopsy, but not present to sign consent: Body to morgue.**
- [ ] **Unable to contact legal next of kin. Body to morgue.**
- [ ] **Family consents to autopsy. Complete remainder of section 4.**

Physician signature _____

***** COMPLETE THIS PORTION OF SECTION 4 ONLY IF THE FAMILY CONSENTS TO AUTOPSY*****

I (We) _____, (relationship-see list above) _____ of (decedent) _____, hereby authorize The University of Texas Medical Branch Hospitals, its physicians and representatives to perform an autopsy as specified below upon the body of the above named decedent.

******A postmortem examination (autopsy) is performed to determine the cause of death and to provide information to physicians that may contribute to the care and treatment of living patients. An autopsy consists of a complete external and internal examination with inspection, removal and retention of any organs related to the cause of death, effects of treatment, or other co-existing significant disease states. Once removed, some organs may be retained to provide complete diagnostic information, and for teaching purposes for health care professionals. Retained organs will be disposed of in accordance with customary medical practice. Retained specimens may also be used for research that could potentially benefit future patients. Specimens will only be used in research projects that ensure patient confidentiality and that have been approved by the Institutional Review Board (a UTMB committee that protects the rights and welfare of human research subjects). The autopsy will not interfere with embalming or a family's desire to have an open casket memorial service. Consent for autopsy is voluntary and can be restricted as to what organs should not be removed or retained.***

SPECIAL INSTRUCTIONS (Such as restrictions or religious prohibitions): _____

Signature of next-of-kin: _____ Address: _____

Witness _____ City, State Zip _____

Witness _____ Phone: _____

SECTION 5: DISPOSITION OF THE BODY

To be completed by Physician

I(We) Raymond Allen Sr., (relationship) ~~Raymond Allen~~ FATHER of (decedent), Raymond Allen., do hereby accept responsibility for disposition of the body and hereby authorize The University of Texas Medical Branch Hospitals to

- [X] Release the body to (name, city, and phone number of funeral home or other Institution): P.R. Johnson Family Mortuary Phone # 409-762-8470
- [ ] Dispose of the body in accordance with customary medical practice. Families may choose this option for stillbirths and neonates less than 28 days old.

Signatures:

Legal next-of-kin: Raymond Allen

Witness: _____

Witness: _____

Date: 2/29/2012

Print name: Raymond Allen.

Address: 2526 Avenue L

City, State Zip Galveston, TX

Phone: 409-497-4446 / 409-599-8071

Note: If the legal next-of- kin is not in the hospital, telephone consent may be obtained for disposition of body. A detailed instruction follows this form.

IF PT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

02/27/12 11.5
DM 02-27-74
2467054N
FEBTWELVE,FOX
30071643

AUTHORIZATION FOR POST-MORTEM PROCEDURES PAGE 2 OF 3

Medical Record Form 5012-Rev. 7/25/2008
The University of Texas Medical Branch Hospitals
Galveston, Texas

SECTION 6: CHECKLIST — *To be completed as designated*

For TDCJ inmates, items 7 and 8 are not applicable (N/A).

Physician: Completed by: Jason B. Welch, D.O.

	Circle On		
1. Death note written in EPIC	(Yes)		
2. Print name of Certifying physician: Jason B Welch			
3. Death reported to Galveston County Medical Examiner (ext. 24004) Time: 16:09 Investigator: John Florence	(Yes)	Not Required	
4. Medicolegal autopsy ordered by Medical Examiner?	(Yes)	No	
5. Successfully notified legal next-of-kin (and/or TDCJ)?	(Yes)	No	
6. Physician to enter patient information via online TER Death Registration program with Texas Department of Health Services upon receipt of email from funeral home			
7. Autopsy authorization section completed, witnessed, and signed (Non-Medical Examiner cases only)	Yes	(No)	N/A
8. Print name and pager # of physician to be notified before autopsy			
9. Funeral home disposition completed with legal next-of-kin?	(Yes)	No	N/A

Nursing: Completed by: Sha Janka

1. Notify Southwest Transplant Alliance (800-201-0527) Time: 1538 Confirmation # 261026	(Yes)		
2. Verified that patient ID band is on body			
3. Personal belongings released to funeral home, family, GCME, hospital morgue (circle one)	Yes	No	(N/A)

4. Body to be released to (check one):
   - ☐ Funeral home: Form 5012, current and old medical records to Autopsy services.
   - ☐ Hospital morgue: Transportation notified. Form 5012, current and old medical records to Autopsy Service.
   - ☑ GCME: Form 5012, current and old medical records to Autopsy services.
5. Page the Nurse Administrator to review paperwork prior to release of the body _____ (Administrator initial)

SECTION 7: MORGUE ENTRY — *To be completed by Transportation*

Transportation:

Body transported to hospital morgue and entered in mortuary book — Yes

SECTION 8: RELEASE OF BODY — *To be completed by Autopsy or Nursing Staff*

Notify funeral home or GCME for release? Date: 2/29/2012 Time: 1545 By: Sha Janka

E.R. ~~Johnston Funeral Home~~ Carnes Funeral Home
Name of funeral home or GCME

~~Brandon Vo~~ Sha Janka
Name of hospital personnel

Signature of representative

~~Morgue Director~~ RN
Title of hospital personnel

ID checked prior to release: SS / W
Initial

ID checked prior to release: SS (~~4844~~ 1925)
Initial

Received personal belongings No Personal Belongings / 2/29/2012
Signature Date

IF PT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

AUTHORIZATION FOR POST-MORTEM PROCEDURES PAGE 3 OF 3

Medical Record Form 5012-Rev. 7/25/2008

The University of Texas Medical Branch Hospitals
Galveston, Texas

02/27/12 11:54
345 305 N 3M 02-27-74
FEATHERLYE, TOX
77771-4731

FEBTWELVE, FOX | ID:346705N | 27-FEB-2012 12:12:50 | UTMB HOSPITALS

27-FEB-1974 (38 yr)
Male Black

Room:J4B
Loc:0

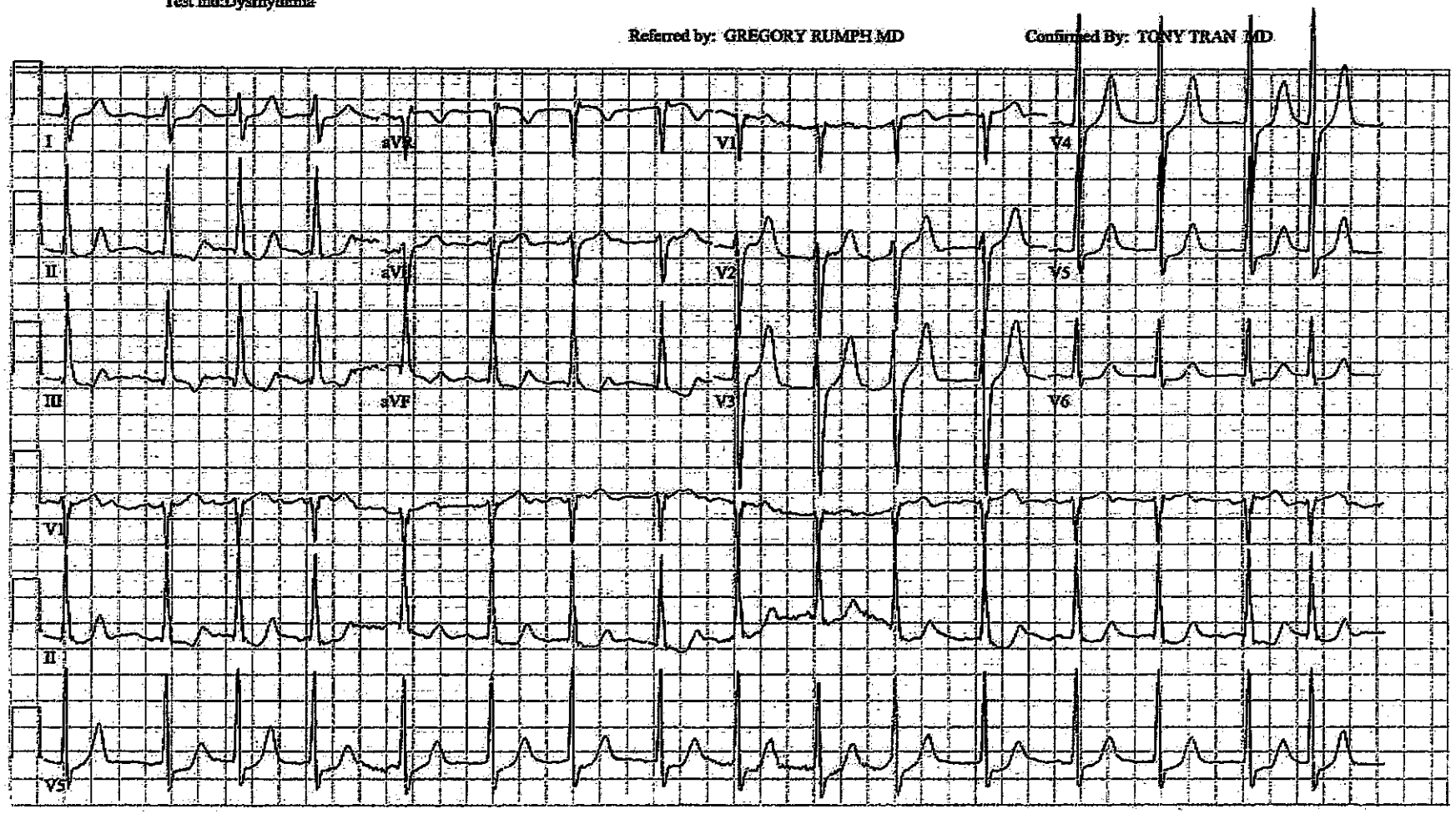
Vent. rate	97	BPM
PR interval	*	ms
QRS duration	112	ms
QT/QTc	334/424	ms
P-R-T axes	* 91	-9

Atrial fibrillation
Rightward axis (90 to 109)
ST segment depressions and T wave abnormality, consider inferior ischemia or digitalis effect
Abnormal ECG
No previous ECGs available
Confirmed by TRAN MD, TONY (10641) on 2/29/2012 10:48:58 PM

Technician:MARK/ER MAHADY
Test ind:Dysrhythmia

Referred by: GREGORY RUMPH MD

Confirmed By: TONY TRAN MD



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 51

EID:10641 EDT: 22:48:29-FEB-2012 ORDER: ACCOUNT: 30001643128

UTMB Health

Hospital Encounter

Raymond Luther Allen (MR# 334674P)

Admission Information - Patient Record Only

Arrival Date/Time:	02/27/2012 11:54 AM	Admit Date/Time:	None	IP Adm. Date/Time:	None
Admission Type:	Emergency Admission	Admission Source:	Er - Admission Or Observation	Admit Category:	Id- Inpatient Discharge
Means of Arrival:	Ems	Primary Service:	Mpu- Pulmonary Medicine	Secondary Service:	N/A
Transfer Source:	None	Service Area:	Utmb At Galveston	Unit:	J4b-ccu/micu
Admit Provider:	Gregory E Rumph, MD	Attending Provider:	Gregory E Rumph, MD	Referring Provider:	None

Hospital Account

Hospital Account #
30001943128

Registration

Admit Date	Admit Time	Room	Bed	Patient Flag
Feb 27, 2012	4:49 PM CDT	J4B J4B 02 [934]	J4B 02 [934]	Non UT-MED [3]

Patient Demographics

Name	Patient ID	SSN	Sex	Birthdate
Allen, Raymond Luther	334674P	xxx-xx-5343	Male	08/30/77 (DECEASED)

Address	Phone	EMail	Employer
7218 SYCAMORE GALVESTON TX 77550	409-986-6184 (H) 409-762-8040 (W)		OTHER EMPLOYER-SIMPS GALVESTON TX 77550

Reg Status	PCP	Date Last Verified	Next Review Date
	Unknown		

Marital Status
Married

Treatment Team

Provider	Role	From	To
Gregory E Rumph, MD	Admitting Provider		
Gregory E Rumph, MD	Attending Provider	02/27/12 1230	02/27/12 2252
Gulshan Sharma, MD	Attending Provider	02/27/12 2252	03/15/12 1133
Shawn P Nishi, MD	Attending Provider	03/15/12 1133	N/A
Ifeoma C Nwelue, MD	*Resident Invision Interface	N/A	N/A
None	*Resident Invision Interface	N/A	02/27/12 2252
Casey L Skelton, RN	Primary Nurse	02/27/12 1245	02/27/12 2044
Rebecca A Stanier, RN	Primary Nurse	02/27/12 1316	02/27/12 2044
Siva Krishna Mannem, MBBS	Residents	02/27/12 1711	N/A
Meagan J Hoetmer, RN	Primary Nurse	02/27/12 1916	N/A
Ericka M Gaddis, RN	Primary Nurse	02/27/12 1930	N/A

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	7a- Other Death - Autopsy Performed	None	None	J4b-Ccu/Micu

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
02/27/12 1154	ED Arrival		ED-EMERGENCY DEPT		
02/27/12 1207	ED Roomed	Emerg	ED-EMERGENCY DEPT	102/102	ERT- Emergency Dept
02/27/12 2253	Admit from ED	Inpt	ED-EMERGENCY DEPT	J4B J4B 02/J4B 02	MPU- Pulmonary Medicine
02/29/12 1533	Discharge	Inpt	J4B-CCU/MICU	J4B J4B 02/J4B 02	MPU- Pulmonary Medicine

Allergies as of 2/29/2012

Date Reviewed: 2/29/2012

No Known Allergies

Medical as of 2/27/2012

None

Current Medications (as of 04/13/12)

Outpatient Medications

	Quantity	Refills	Start	End
AMOXICILLIN 500 MG ORAL CAP Sig : 1 po tid x 10 days for ear infection Route: Oral	30	0	5/21/2008	

ED Records

ED Arrival Information

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type	Arrival Complaint
2/27/12 4:49 PM	2/27/2012 11:54 AM	Immediate	EMS	None	MPU- Pulmonary Medicine	Emergency Admission	-

ED Disposition

Admit - ICU

Health

ED Notes

ED Notes signed by Carly L McGrew, SW at 02/29/12 1527

Author:	Carly L McGrew, SW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/29/12 1527	Note Time:	02/29/12 1507		

SW received TC from GPD request pt update. SW referred Detective Sollenberger to ICU CM.

Signed by Carly L McGrew, SW on 02/29/12 1527

ED Notes signed by Carly L McGrew, SW at 02/28/12 1356

Author:	Carly L McGrew, SW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/28/12 1356	Note Time:	02/27/12 1230		
Related Notes:	Original Note by: Carly L McGrew, SW filed at 02/27/12 1613				

Late note **1230**: SW met w/ pt's wife to provide support and was informed pt's name is Raymond Allen (DOB 8/30/77) MRN: 334674P.

Signed by Carly L McGrew, SW on 02/28/12 1356

02/27/12 1613 ED Notes Signed By Carly L McGrew, SW

ED Notes signed by April Martinez, LMSW at 02/27/12 2251

Author:	April Martinez, LMSW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/27/12 2251	Note Time:	02/27/12 2250		

SW escorted pt's family to ICU.

Signed by April Martinez, LMSW on 02/27/12 2251

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 2214

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 2214	Note Time:	02/27/12 2214		

Report given to Steve RN.

Signed by Ericka M Gaddis, RN on 02/27/12 2214

ED Notes signed by April Martinez, LMSW at 02/27/12 2148

Author:	April Martinez, LMSW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/27/12 2148	Note Time:	02/27/12 2148		

SW provided support to pt's aunts and wife.

Signed by April Martinez, LMSW on 02/27/12 2148

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 2138

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 2138	Note Time:	02/27/12 2136		

Wife at bedside. Pt remains on ventilator and cm, fluids continue to infuse without complication. BP remains elevated.

Signed by Ericka M Gaddis, RN on 02/27/12 2138

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 2127

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 2127	Note Time:	02/27/12 2052		

MD at bedside.

Signed by Ericka M Gaddis, RN on 02/27/12 2127

ED Provider Notes signed by Gregory E Rumph, MD at 02/27/12 2107

Author:	Gregory E Rumph, MD	Service:	(none)	Author Type:	STAFF
Filed:	02/27/12 2107	Note Time:	02/27/12 1233		

EMERGENCY PHYSICIAN RECORD CRITICAL CARE

Time Seen: 12:33 PM
Exam Limited By: Intubated
EMS treatment prior to arrival: CPR, resuscitation, intubation

HPI
Chief Complaint: unresponsive and loss of pulse
Onset/Duration: just prior to arrival
Initial Findings:by paramedic, no respirations and asystolic
Pre-Hospital Treatment: CPR, Epinephrine 4 mg, intubated, IV access, Iv fluids and oxygen

Report per EMS and Police: patient reported to have been apprehended by police and tasered. Suspicion for PCP and/or cocaine use. After the taser, was noted to be unresponsive and EMS called to scene. Police indicate that the patient was acting bizarrely taking off clothes and had jumped and run from a balcony twice before running into a parked car and then taking off clothes. At that point police moved to apprehend the patient, became concerned about violent behavior and tasered patient.

Review of Systems
Unable to evaluate

Past Medical History
No past medical history on file.

Tetanus vaccination status reviewed: tetanus status unknown to the patient.

Medications
Current facility-administered medications

Medication	Dose	Route	Frequency	Last Rate	Last Dose
• DOPamine 1.6 mg/ml 800 mg/500 mL (1,600 mcg/mL) infusion	15 mcg/kg/min	Intravenous	TITRATE		Last Dose: 10 mcg/kg/min at 02/27/12 1430
• NOREpinephrine (LEVOPHED) 4 mg in D5W 250 mL infusion	0.05 mcg/kg/min	IV Infusion	CONTINUOUS		Last Dose: 0.05 mcg/kg/min at 02/27/12 1646
• pantoprazole (PROTONIX) 40 mg in D5W piggyback	40 mg	IV Piggyback	Q24H		Last Dose: 40 mg at 02/27/12 1416
• NaCl 0.9% (NS) IV infusion		Intravenous	CONTINUOUS	150 mL/hr (02/27/12 1954)	

No current outpatient prescriptions on file.

Allergies
No Known Allergies

Social History
History
Social History
- Marital Status: N/A
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Occupational History
- Not on file.

Social History Main Topics
- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics Concern
- Not on file

Social History Narrative
- No narrative on file

Family History
No family history on file.

Nursing Assessment Reviewed: yes
Physical Exam
BP 173/115 | Pulse 87 | Temp(Src) 34.3 °C (93.7 °F) (Bladder) | Resp 24 | Wt 100 kg (220 lb 7.4 oz) | SpO2 100%

General: backboard prior to arrival, (+) unconsciousness and (-) convulsing
Head: non-tender, no swelling and no obvious injury
Neck: trachea midline, (-) decreased/limited range of motion and (-) lymphadenopathy
Eyes: fixed and dilated on arrival
ENT: intubated. No response to stimulus. NO obvious stepoffs or fractures.
Glasgow Coma Score: 3T
Eyes Open - none (1)
Speech - none (1)
Motor - none (1)
Cardiovascular: weak pulse on arrival and then became pulseless
Respiratory: intubated, clear breath sounds bilaterally, no epigastric sounds. 7.5ETT by EMS.
Abdomen: soft, non-tender, no organomegaly, normal bowel sounds, (-) distention and (-) ecchymosis
Genital/Rectal: normal external inspection
Back: normal inspection and no stepoff of the spine and no trauma/abrasion noted to the back
Skin: intact and cool, dry
Extremities: atraumatic and (-) swelling

Neuro/Psych: GCS3.

Initial EKG Monitoring: narrow complex and sinus rhythm

Procedures and Interventions:
Cental line placed - sterile technique, right internal jugular vein under m y supervision by Dr. De Los Santos, pulmonary fellow
CPR
Foley catheter
Hypothermia protocol

Labs
Recent Results (from the past 24 hour(s))
LIPASE, SERUM
Collection Time
2/27/12 1:40 PM

Component	Value	Range
• LIPASE	67	0 - 220 (U/L)

HEPATIC FUNCTION PANEL (80076) (ALB,T.PRO,BILI T,BU/BC,ALT,AST,ALK PHOS)
Collection Time
2/27/12 1:40 PM

Component	Value	Range
• TOTAL BILI	0.4	0.1 - 1.1 (MG/DL)
• BILI UNCON	0.5	0.1 - 1.1 (MG/DL)
• BILI CONJ	0.0	0.0 - 0.3 (MG/DL)
• T PROTEIN	6.7	6.3 - 8.2 (G/DL)
• ALBUMIN	4.0	3.5 - 5.0 (G/DL)
• ALK PHOS	68	34 - 122 (U/L)
• ALT(SGPT)	169 (*)	9 - 51 (U/L)
• AST(SGOT)	147 (*)	13 - 40 (U/L)

BASIC METABOLIC PANEL (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, CA)
Collection Time
2/27/12 1:40 PM

Component	Value	Range
• NA	154 (*)	135 - 145 (MMOL/L)
• K	5.4 (*)	3.5 - 5.0 (MMOL/L)
• CL	107	98 - 108 (MMOL/L)
• CO2 TOTAL	<5	23 - 31 (MMOL/L)
• AGAP	N/A	2 - 16
• BUN	8	7 - 23 (MG/DL)
• GLUCOSE	225 (*)	70 - 110 (MG/DL)
• CREATININE	2.02 (*)	0.60 - 1.25 (MG/DL)
• CALCIUM	10.3	8.6 - 10.6 (MG/DL)

URINALYSIS
Collection Time
2/27/12 1:40 PM

Component	Value	Range
• APPEARANCE	Hazy (*)	
• COLOR	Yellow	
• PH	6.0	4.8 - 8.0
• SP GRAVITY	1.013	1.003 - 1.030

• GLU U QUAL	NORMAL	> NEGATIVE
• BLOOD	TRACE (*)	> NEGATIVE
• KETONES	5 mg/dL (*)	> NEGATIVE
• PROTEIN	10mg/dL (*)	> NEGATIVE
• BILIRUBIN	NEGATIVE	> NEGATIVE
• NITRITE	NEGATIVE	> NEGATIVE
• LEUK ESTER	NEGATIVE	> NEGATIVE
• UROBILIN	2.0mg/dL (*)	> 0-1mg/dL
• SQ EPITH	1	0 - 2 (/HPF)
• WBC/HPF	1	0 - 5 (/HPF)
• RBC/HPF	6 (*)	0 - 3 (/HPF)
• BACTERIA	FEW (*)	> NEGATIVE
• MUCOUS	MODERATE (*)	> NEGATIVE
• SPERM	13	(/HPF)

CBC WITH DIFF

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• WBCx10^3	11.4 (*)	4.0 - 10.0 (/CMM)
• RBCx10^6	4.49	4.40 - 5.65 (/CMM)
• HGB	13.0 (*)	13.5 - 17.0 (G/DL)
• HCT	45.9	40.0 - 50.0 (%)
• MCV	102.2 (*)	80.0 - 96.0 (FL)
• MCH	29.0	27.0 - 32.0 (PG)
• MCHC	28.3 (*)	31.0 - 37.0 (%)
• RDW	13.8	11.6 - 14.0 (%)
• PLTx10^3	234	150 - 400 (/CMM)
• MPV	12.5 (*)	8.0 - 12.0 (FL)
• RDWSD	51.6 (*)	37.8 - 49.2 (FL)
• GRAN%	45.7	40.0 - 73.0 (%)
• LYMPH%	39.2	18.0 - 53.0 (%)
• MONO%	8.9	4.0 - 12.0 (%)
• EOS%	1.4	0.0 - 6.0 (%)
• BASO%	0.2	0.0 - 2.0 (%)
• GRAN#x10^3	5.21	1.60 - 6.40 (/CMM)
• LYMP#x10^3	4.5 (*)	1.0 - 3.9 (/CMM)
• MONO#x10^3	1.0 (*)	0.2 - 0.9 (/CMM)
• EOS#x10^3	0.2	0.0 - 0.5 (/CMM)
• BASO#x10^3	0.0	0.0 - 0.2 (/CMM)
• IMM GRAN %	4.6 (*)	0.0 - 0.6 (%)
• IMM GRAN #	0.5 (*)	0.0 - 0.1 (/CMM)

CK (CREATINE KINASE) + MB

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• CK	522 (*)	33 - 194 (U/L)
• CK-MB	2.1	> -<3.5 (ng/mL)
• CKMB INDEX	0.4	0.0 - 2.5 (%)

TROPONIN I

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• TROPONIN I	0.008	> -<0.030 (ng/mL)

DRUG SCREEN PANEL 2

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• AMP METH	.	
• BARB U	.	
• BENZO U	.	
• COC MET	.	
• METHADONE	.	
• OPIATES	.	
• PCP	.	
• PROPOXY	.	
• THC	.	

SALICYLATE, LEVEL

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• SALICYLATE TLD	N/A (*)	(HOURS)
• SALICYLATE	<10 (*)	(mg/L)

ACETAMINOPHEN, LEVEL

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• ACETAMIN TLD	N/A (*)	(HOURS)
• ACETAMINOP	<10 (*)	(ug/mL)

ETHANOL, LEVEL

Collection Time
2/27/12 1:40 PM

Component	Value	Range
• ALCOHOL	<15	(MG/DL)
• SPEC TYPE	SERUM	

LACTIC ACID PLASMA

Collection Time
2/27/12 1:55 PM

Component	Value	Range
• LACT ACID	N/A	0.3 - 2.6 (MMOL/L)

ACUTE CARE ARTERIAL BLOOD GAS

Collection Time
2/27/12 5:00 PM

Component	Value	Range
• PH ART	7.32 (*)	7.35 - 7.45
• PCO2 ART	42	35 - 45 (MM/HG)
• PO2 ART	47 (*)	80 - 100 (MM/HG)
• HCO3 ART	21 (*)	22 - 26 (MEQ/L)
• ARTERIAL BE	-5.1 (*)	-3.0 - 03.0 (MEQ/L)

CT HEAD W/O CONTRAST

Collection Time
2/27/12 5:50 PM

Component	Value	Range
• CT HEAD W/O CONTRAST		

Value: **********PRELIMINARY**********
CT HEAD WITHOUT CONTRAST

ED Notes (continued)

PROCEDURE: Multiple axial unenhanced CT images of the head have been obtained.

HISTORY:cardiac areest s/p cpr now intubated, pls eval

COMPARISON: Not available

FINDINGS:

The paired midline intracranial structures are centrally located.

At the level of lateral ventricles, there is subtle loss of gray-white matter differentiation along with sulcal effacement suggsetive of cerebral edema.

There is no evidence of a defined mass, mass-effect, hemorrhage.

The basal cisterns appear effaced. The ventricular system are unremarkable for age.

Subcutaneous soft tissue swelling in the left frontoparietal region.

Mucosal thickening of the maxillary, sphenoid ethmoidal sinuses.

Orbital, calvarium and remaining skull base, are within normal limits for age.

IMPRESSION:

The findings as described are suggsetive of cerebral edema. A follow-up study can be obtained for further evolution.

The findings relayed to the clinical team at the time of dictation.

LACTIC ACID PLASMA
Collection Time
2/27/12 8:23 PM

Component	Value	Range
• LACT ACID	1.7	0.3 - 2.6 (MMOL/L)

EKG: interpreted by me
Normal axis, Normal intervals, Normal P-waves, Normal QRS complex, Normal sinus rhythm and Normal ST / T waves
Comparison with prior EKG: none available

X-Rays: reviewed by me
ETT in place, Right IJ in the SVC 2cm above the RA, gastric tube below the diaphragm, no effusion, no fracture, no infiltrate noted

Note
CPR initiated shortly after arrival Vigorous CPR, epinephrine and return of spontaneous pulse. Dopamine started.
Obtained blood from the right femoral artery for blood gas and labs.
Continues to be tachycardic, decision made to keep patient cool, initiate hypothermia protocol. Foley placed.
contines to be hypotensive in the 60-70systolic. Levophed ordered and begun as drip.
Prepping neck for Right ij under ultrasound guidance, Dr. De Los Santos arrived in the ER, pulmonary fellow.

Procedure:
Prepped with chlorhexidine. Short drape applied in emergent situation. Ultrasound probed with sterile cover to right neck and vessel cannulated. Wire introduced and triple lumen catheter advanced to 15cm. Sutured in place, all three ports flush and pulled blood. CX R obtained post procedure. Performed by Dr. De Los Santos under my supervision.

ABG: pH too low to read (<6.6)
Sodium Bicarbonate drip initiated, 150m eq in D5 1/2NS at 125ml/hr
On ventilator, 550cc, +5, 100% O2, rate 14. Overbreathing the vent.

Family notified of critical condition by Dr. deLos Santos.
Protonix given for blood in Og tube, small amount. ON LWIS.

Patient remained critically ill. GCS remains 3. Blood pressure support - weaned dopamine.
Given pavulon during shivering phase of hypothermia, and NS bolus.

Weaned from levophed. Pending ICU transfer to MICU here.

Clinical Impression
Diagnosis/Reason for ED Visit: Cardiac Arrest; Hypotension; cocaine and PCP abuse; acute kidney injury; likely anoxic brain injury

Disposition
Admitted

Condition: critically ill

Care transferred to Dr. Yarima, ER staff. Time: 1900. Patient admitted MICU pending bed availability. Discussed with Dr. De Los Santos, will see patient in ED.

Critical Care Time: 80 minutes excluding procedures

Gregory Rumph, MD
UTMB Emergency Medicine

Signed by Gregory E Rumph, MD on 02/27/12 2107
ED Notes signed by Ericka M Gaddis, RN at 02/27/12 2048

ED Notes (continued)

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 2048 (continued)

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 2049	Note Time:	02/27/12 2048		

MD Krishna Mannem paged and made aware of increased urine output and increased BP.

Signed by Ericka M Gaddis, RN on 02/27/12 2048

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 1954

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1954	Note Time:	02/27/12 1954		

Family at bedside. MD to bedside at this time.

Signed by Ericka M Gaddis, RN on 02/27/12 1954

ED Notes signed by Ericka M Gaddis, RN at 02/27/12 1940

Author:	Ericka M Gaddis, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1940	Note Time:	02/27/12 1932		

Report received. Pt laying supine on stretcer with HOB at 30 degrees. Pt remains intubated with 7.5 ETT at 24cm at the teeth, breathing assisted by ventilator, settings recorded by RT. OG tube also noted to intermittent suction, BRB noted in return. Pupils 1 cm and nonreactive. Pt unresponsive to painful stimuli, no spontaneous movement noted. L EJ PIV noted, saline locked. R IJ triple lumen central line noted with antibiotics infusing without complication. Foley noted to have 140ml urine output, urine cleared and value recorded in doc flowsheet. Urine noted to have red tint. Induced hypothermia vest, blanket and headpiece remain in place and running. Skin intact, cool to touch. Pt remains on cm. Will continue to monitor closely.

Signed by Ericka M Gaddis, RN on 02/27/12 1940

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1904

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1904	Note Time:	02/27/12 1903		

Bedside nursing report given to E. Gaddis RN and M. Hoetmer RN.

Signed by Rebecca A Stonler, RN on 02/27/12 1904

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1855

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1855	Note Time:	02/27/12 1855		

Bicarbonate gtt stopped. Vancomycin 1 gm and Zosyn IVPB initiated.

Signed by Rebecca A Stonler, RN on 02/27/12 1855

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1841

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1841	Note Time:	02/27/12 1839		

Dr. Shah at bedside.

Signed by Rebecca A Stonler, RN on 02/27/12 1841

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1824

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1824	Note Time:	02/27/12 1824		

Spoke with Gina from SW transplant, reports she will come to ED.

Signed by Rebecca A Stonler, RN on 02/27/12 1824

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1818

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1818	Note Time:	02/27/12 1817		

SW transplant notified @ 1818. ID# 261026 spoke with Yvonne Benton.

ED Notes (continued)

Signed by Rebecca A Stonler, RN on 02/27/12 1816

ED Notes signed by Carly L McGrew, SW at 02/27/12 1813

Author:	Carly L McGrew, SW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/27/12 1813	Note Time:	02/27/12 1230	Note Status:	Revised
Related Notes:	Addendum by: Carly L McGrew, SW filed at 02/28/12 1356				

Late note **1230**: SW met w/ pt's wife to provide support and was informed pt's name is Randy Allen (DOB 8/30/77)

Signed by Carly L McGrew, SW on 02/27/12 1813

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1809

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1809	Note Time:	02/27/12 1808		

Pt continues to drain dark red blood from OG tube. Urine pink tinged and clear, increased output noted.

Signed by Rebecca A Stonler, RN on 02/27/12 1809

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1807

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1807	Note Time:	02/27/12 1806		

Pt taken to CT scan via stretcher, no ectopy noted. VS stable. No movement noted, unresponsive. Pt returned to rm 102 without incident.

Signed by Rebecca A Stonler, RN on 02/27/12 1807

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1723

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1723	Note Time:	02/27/12 1722		

Levophed gtt stopped at this time.

Signed by Rebecca A Stonler, RN on 02/27/12 1723

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1720

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1720	Note Time:	02/27/12 1719		

Dr. Shah at bedside reporting he wants to obtain CT scan during induced hyperthermia, MD discussed risk of moving pt with wife.

Signed by Rebecca A Stonler, RN on 02/27/12 1720

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1707

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1707	Note Time:	02/27/12 1706		

Medical student at bedside drawing ABG, Dr. DeLos Santos present.

Signed by Rebecca A Stonler, RN on 02/27/12 1707

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1646

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1646	Note Time:	02/27/12 1645		

Pt received 2 liters of chilled NS. Noted increased urine output, levophed decreased to 0.05mcg. Wife at bedside.

Signed by Rebecca A Stonler, RN on 02/27/12 1646

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1630

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1630	Note Time:	02/27/12 1628		

ED Notes (continued)

2 mg ativan iv, ICU resident at bedside. Induced hypothermia continues. Icepacks applied to groin and both axilla. HR now 112. Dopamine gtt stopped.

Signed by Rebecca A Stonler, RN on 02/27/12 1530

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1521

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1521	Note Time:	02/27/12 1520		

L Leg IO removed without difficulty, scant bleeding noted to site.

Signed by Rebecca A Stonler, RN on 02/27/12 1521

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1507

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1507	Note Time:	02/27/12 1506		

Pt given 10 mg pancuronium IVP. Vent Settings: Rate:14, PEEP: 5, TV: 550, FIO2: 100%.

Signed by Rebecca A Stonler, RN on 02/27/12 1507

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1444

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1444	Note Time:	02/27/12 1442		

Dopamine decreased to 10mcg at this time. BP: 108/56 HR: 122. Pt remains unresponsive, noted "goose bumps", orders given by Dr. Rumph for paralytic.

Signed by Rebecca A Stonler, RN on 02/27/12 1444

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1418

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1418	Note Time:	02/27/12 1418		

Protonix 40 mg ivpb initiated. Wife at bedside.

Signed by Rebecca A Stonler, RN on 02/27/12 1416

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1412

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1412	Note Time:	02/27/12 1408		

Induced hypothermia ongoing, body temp 35.4C. Pt remains unresponsive, intubated. Family at bedside. Noted dark red blood draining from OG tube, currently on LIWS.

Signed by Rebecca A Stonler, RN on 02/27/12 1412

ED Notes signed by Rebecca A Stonler, RN at 02/27/12 1340

Author:	Rebecca A Stonler, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1340	Note Time:	02/27/12 1338		

Detective Sollenberger badge # 364 reports pt was tazed x 2 simultaneously, reported pt jumped x 2 off 2nd story balcony prior to incident. Dr. Rumph at bedside performing FAST exam.

Signed by Rebecca A Stonler, RN on 02/27/12 1340

ED Notes signed by Carly L McGrew, SW at 02/27/12 1257

Author:	Carly L McGrew, SW	Service:	(none)	Author Type:	CARE MANAGER
Filed:	02/27/12 1257	Note Time:	02/27/12 1255		

SW escorted pt's mother, wife, brother's, and other family members to family room. SW provided update and ongoing support and monitoring.

Signed by Carly L McGrew, SW on 02/27/12 1257

ED Notes signed by Andrea L Gillespie, RN at 02/27/12 1230

Author:	Andrea L Gillespie, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1230	Note Time:	02/27/12 1227		

ED Notes (continued)

1218 Dopamine increased to 20mcg/kg/min
1225 Epi 1mg IVP given by Dr. Rumph
1227 Levophed 4mg/250ml started by R. Stonler RN at .05mg/kg/min.

Signed by Andrea L Gillespie, RN on 02/27/12 1230

ED Notes signed by Teah D Bland, RN at 02/27/12 1227

Author:	Teah D Bland, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1227	Note Time:	02/27/12 1227		

Social worker with wife also reports PCP abuse.

Signed by Teah D Bland, RN on 02/27/12 1227

ED Notes signed by Teah D Bland, RN at 02/27/12 1226

Author:	Teah D Bland, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1226	Note Time:	02/27/12 1220		

1152 pt arrived by GEMS pt was reportedly seen by Sherriff's office, pt reported cocaine use to police officer was "stunned or dry tazed at least two times" pt received on backboard. 18G left EJ noted upon arrival, pt has Left IO in place by EMS. 7.5 ETT tube placed PTA. BBS auscultated. Co2 detection noted. Visible chest rise and fall. no pulse noted CPR initiated. Dr. Rumph at bedside. RT at bedside. Pt placed on cardiac monitor. 1155 femoral pulse felt, irregular sinus noted on monitor. 1 epi given. 1207 OG placed by R. Stonler RN, hypothermia induced. Dr. Rumph placed right femoral stick for blood. Dopamine started at 15 mcg/kg/min.

Signed by Teah D Bland, RN on 02/27/12 1226

ED Notes signed by Andrea L Gillespie, RN at 02/27/12 1209

Author:	Andrea L Gillespie, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/27/12 1209	Note Time:	02/27/12 1209		

Dr. Rumph in room upon pt arrival. No pulse detected and CPR started.

Signed by Andrea L Gillespie, RN on 02/27/12 1209

D/C Summaries - Encounter Notes

D/C Summaries signed by Jason Bennett Welch, DO at 02/29/12 1645

Author:	Jason Bennett Welch, DO	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 1645	Note Time:	02/29/12 1637		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/29/12 1853				

Date of Service: 2/29/2012

ADMIT DATE: 2/27/2012
DISCHARGE DATE: 2/29/2012
ATTENDING MD: Dr. Nishi
RESIDENT MD: Dr. Welch
PCP: UNCOVERED

REASON FOR ADMISSION
S/p cardiac arrest
FINAL DIAGNOSIS: (the reason, after study, for admitting the patient to the hospital)
Anoxic brain injury secondary to prolonged hypoxemia associated with cardiac arrest; cocaine+, PCP+, THC+; s/p "tasing"

SECONDARY DIAGNOSIS: (any diagnosis that, on this admission, required clinical evaluation, therapeutic treatment,

diagnostic procedures, extended hospital stay, or additional nursing care/monitoring)
Patient Active Hospital Problem List:
No active hospital problems.

PRINCIPAL PROCEDURE:
Hypothermia protocol s/p cpr

ADDITIONAL PROCEDURES:
none

SIGNIFICANT LAB/X-RAYS:

	2/29/2012 00:45	2/29/2012 08:05	2/29/2012 08:20	2/29/2012 08:40
APTT MN NM	30		30	
APTT PATIENT	34		37	
WBCx10^3	25.8 (H)		21.6 (H)	
RBCx10^6	4.97		4.70	
HGB	14.4		13.4 (L)	
HCT	42.1		40.5	
MCV	84.7		86.2	
MCH	29.0		28.5	
MCHC	34.2		33.1	
RDW	13.6		13.7	
PLTx10^3	144 (L)		107 (L)	
MPV	11.2		10.4	
POLYCHROM	2+		2+	
BURR/ACANT	2+			
GRAN%	91.3 (H)		87.8 (H)	
LYMPH%	3.8 (L)		6.1 (L)	
MONO%	4.3		5.2	
EOS%	0.0		0.4	
BASO%	0.1		0.1	
GRAN#x10^3	23.52 (H)		19.00 (H)	
LYMP#x10^3	1.0		1.3	
MONO#x10^3	1.1 (H)		1.1 (H)	
EOS#x10^3	0.0		0.1	
BASO#x10^3	0.0		0.0	
BANDS	MKD INCR (A)		MKD INCR (A)	
RDWSD	40.9		43.2	
IMM GRAN %	0.5		0.4	
IMM GRAN #	0.1		0.1	
PH ART		7.18 (AA)	7.18 (AA)	7.08 (AA)
PCO2 ART		46 (H)	40	66 (W)
PO2 ART		58 (L)	234 (H)	228 (H)
HCO3 ART		17 (AA)	15 (AA)	18 (AA)
THB ART				14.6
%O2HB ART				98.3
%COHB ART				0.6
%METHB ART				0.6
VOL%O2 ART				20.6
NA				146 (H)
K+				5.1 (H)
AC CA IONZ				4.90
GLUCOSE				120 (H)
ARTERIAL BE		-11.2 (L)	-12.9 (L)	-12.9 (L)
NA	147 (H)		146 (H)	

K	3.3 (L)		5.3 (H)	
CL	120 (H)		122 (W)	
CO2 TOTAL	14 (L)		15 (L)	
AGAP	13		9	
BUN	22		25 (H)	
GLUCOSE	78		107	
CREATININE	3.60 (H)		4.20 (H)	
TOTAL BILI	0.2			
BILI UNCON	0.4			
BILI CONJ	0.0			
CALCIUM	7.2 (L)		7.0 (L)	
MAGNESIUM	3.1 (H)		2.7 (H)	
T PROTEIN	5.2 (L)			
ALBUMIN	2.6 (L)			
TROPONIN I	0.743 (H)		0.703 (H)	
LACT ACID	1.4		1.2	
ALK PHOS	117			
ALT(SGPT)	628 (H)			
AST(SGOT)	1013 (W)			
CK	>14,400 (A)		>14,400 (A)	
CK-MB	231.0 (H)		213.0 (H)	
CKMB INDEX	N/A		N/A	

HOSPITAL COURSE:
Patient is a 38 year old African American male admitted from the ER s/p out of hospital cardiac arrest. Per EMS and police, pt had been exhibiting bizarre behavior and jumped off 2 story balcony. Police reportedly "dry tazed" him twice at which time he became unresponsive and had no pulse. CPR was started, received epinephrine and he had ROSC in 5 minutes. He was intubated in the field. Upon arrival to UTMB, he again lost pulse and had CPR lasting 5 minutes with return of circulation. He initially required pressors due to hypotension but were able to wean off while in ER. Hypothermia protocol was initiated. Initial ABG showed severe acidosis with pH <6.6 and sodium bicarbonate drip was started. Also received 1 dose of vanc and zosyn. Drug screen positive for PCP, cocaine, and THC.
In MICU hypothermia protocol was completed. Upon rewarming patient required vasopressor support but had no arrhythmias. At end of rewarming apnea test was done and he showed no spontaneous respirations at 8 minutes off mechanical ventilator. He had no pupillary response, no corneal reflex, no gag, and did not respond to noxious stimuli. Brain death was reported to patients family and the decision to withdraw care was made. He expired at 15:33PM.

CONDITION:
Deceased

DIET:
N/a

ACTIVITY:
N/a

DISCHARGE MEDICATIONS:
There are no discharge medications for this patient.

WOUND CARE: n/a

DISCHARGE: Deceased: autopsy mandated by county medical examiner

FOLLOW-UP APPOINTMENT:

N/a

Signed by Jason Bennett Welch, DO on 02/29/12 1645

H&P - Encounter Notes

H&P signed by Zena B Mercer Welsh, RN at 02/29/12 0748

Author:	Zena B Mercer Welsh, RN	Service:	(none)	Author Type:	NURSE CLINICIAN
Filed:	02/29/12 0748	Note Time:	02/29/12 0748		

SWT called. Reference #261213.

Signed by Zena B Mercer Welsh, RN on 02/29/12 0748

H&P signed by Shawn P Nishi, MD at 02/28/12 0911

Author:	Shawn P Nishi, MD	Service:	(none)	Author Type:	STAFF
Filed:	02/28/12 0911	Note Time:	02/28/12 0026		
Related Notes:	Original Note by: Shawn P Nishi, MD filed at 02/28/12 0903				

I have also reviewed the H &P by Dr. McCracken and I agree with the history, physical examination, assessment and plan from the 2/28/12 admission.

Fox Febtwelve is a 38 year old male s/p code from taser while intoxicated with PCP, cocaine, THC. Comatose on arrival with ROSC <5 min x2 and initiated on hypothermia protocol.

-pupils fixed, dilated, no spontaneous respirations, initial hypertension but sudden hypotension requiring NE for support but remains on hypothermia currently

-acutely hepatitis, rhabdomyolysis, metabolic acidosis, CT head with cerebral edema and likely herniation

-DC hypothermia, passive rewarming and neuro assessment with apnea test once >36C

Prognosis poor in this setting

I spent 30 minute(s) on date 2/28/2012 personally caring for this critically ill patient on the unit/floor. The patient was critically ill due to Acute Renal Failure, Drug Overdose, Hepatic F ailure, Metabolic Acidosis, Respiratory Failure, Shock/Hemodynamic Instability, Other: neuro failure.

I performed the following services: direct hands-on care of the patient, reviewed im agine studies and reviewed test results and interpre tation of physiologic parameters.

Signed by Shawn P Nishi, MD on 02/28/12 0911

02/28/12 0903 H&P By Shawn P Nishi, MD

H&P signed by Shawn P Nishi, MD at 02/28/12 0903

Author:	Shawn P Nishi, MD	Service:	(none)	Author Type:	STAFF
Filed:	02/28/12 0903	Note Time:	02/28/12 0026	Note Status:	Revised
Related Notes:	Related Note by: Jennifer L McCracken, MD filed at 02/28/12 0631				
	Addendum by: Shawn P Nishi, MD filed at 02/28/12 0911				

See fellows note and my attestation from earlier 2/27/12

Signed by Shawn P Nishi, MD on 02/28/12 0803

H&P signed by Jennifer L McCracken, MD at 02/28/12 0631

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/28/12 0631	Note Time:	02/28/12 0028		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/28/12 0803				
	Original Note by: Jennifer L McCracken, MD filed at 02/28/12 0143				

Date of Service: 2/27/2012

CHIEF COMPLAINT:
S/p cardiac arrest

HPI
Patient is a 38 year old Black or African American male admitted from the ER s/p out of hospital cardiac arrest. Per EMS and police, pt had been exhibiting bizarre behavior and jumped off 2 story balcony. Police dry tazed him twice at which time he became unresponsive and had no pulse. CPR was started, received epinephrine and he had ROSC in 5 minutes. He was intubated in the field. Upon arrival to UTMB, he again lost pulse and had CPR lasting 5 minutes with return of circulation. He initially required pressors due to hypotension but they were able to weaned off while in ER. Hypothermia protocol was initiated. Initial ABG showed severe acidosis with pH <6.8 and sodium bicarbonate drip was started. Also received 1 dose of vanc and zosyn. Drug screen positive for PCP, cocaine, and THC.

ALLERGY:
Review of patient's allergies indicates no known allergies.

HISTORIES
MEDICAL HISTORY:
None per family

SURGICAL HISTORY:
None per family

SOCIAL HISTORY:
+ drug abuse

FAMILY HISTORY:

No family history on file.

MEDICATIONS
Home Medications:
No prescriptions prior to admission

Hospital Medications:
Current facility-administered medications

Medication	Dose	Route	Frequency	Last Rate	Last Dose
• pantoprazole (PROTONIX) 40 mg in D5W piggyback	40 mg	IV Piggyback	Q12H		
• DOPamine 1.6 mg/ml 800 mg/500 mL (1,600 mcg/mL) infusion	15 mcg/kg/min	Intravenous	TITRATE		Last Dose: 10

• NORepinephrine (LEVOPHED) 4 mg in D5W 250 mL infusion	0.05 mcg/kg/min	IV Infusion	CONTINUOUS	mcg/kg/min at 02/27/12 1430 Last Dose: 0.05 mcg/kg/min at 02/27/12 1646
• NaCl 0.9% (NS) IV infusion		Intravenous	CONTINUOUS	150 mL/hr (02/27/12 1954)
• midazolam (VERSED) injection 2 mg	2 mg	IV Push	PRN - SEE INSTRUCTIONS	
• midazolam (VERSED) 50 mg in NaCl 0.9% (NS) infusion	1 mg/hr	IV Infusion	TITRATE	
• FENTanyl PF (SUBLIMAZE (P/F)) 50 mcg/mL injection 50 mcg	50 mcg	Slow IV Push	PRN - SEE INSTRUCTIONS	
• FENTanyl PF (SUBLIMAZE (P/F)) 2,500 mcg in NaCl 0.9% (NS) 250 mL infusion	25 mcg/hr	IV Infusion	TITRATE	

REVIEW OF SYMPTOMS
Unable to obtain

PHYSICAL EXAMINATION
BP 197/161 | Pulse 88 | Temp(Src) 32.7 °C (90.9 °F) (Bladder) | Resp 23 | Wt 100 kg (220 lb 7.4 oz) | SpO2 100%

Constitutional: unresponsive, intubated, GCS 3
HEENT: pupils 1 mm, nonresponsive, ETT in place
Neck: no bruit, R IJ in place
Cardiovascular: RRR, no murmurs appreciated
Respiratory: CTAB anteriorly
Gastrointestinal: soft, normoactive bowel sounds
Extremities: no cyanosis, clubbing or edema
Musculoskeletal: no joint swelling or deformities
Neurologic: comatose, GCS 3
Skin: no rashes or lesion

Review of data:

	2/27/2012 13:40
WBCx10^3	11.4 (H)
RBCx10^6	4.49
HGB	13.0 (L)
HCT	45.9
MCV	102.2 (H)
MCH	29.0
MCHC	28.3 (L)
RDW	13.8

PLTx10^3	234
MPV	12.5 (H)
GRAN%	45.7
LYMPH%	39.2
MONO%	8.9
EOS%	1.4
BASO%	0.2
GRAN#x10^3	5.21
LYMP#x10^3	4.5 (H)
MONO#x10^3	1.0 (H)
EOS#x10^3	0.2
BASO#x10^3	0.0

	2/27/2012 17:00
PH ART	7.32 (L)
PCO2 ART	42
PO2 ART	47 (L)
HCO3 ART	21 (L)
ARTERIAL BE	-5.1 (L)

	2/27/2012 13:40	2/27/2012 13:55	2/27/2012 20:23	2/27/2012 20:37
NA	154 (H)			141
K	5.4 (H)			2.7 (AA)
CL	107			105
CO2 TOTAL	<5			22 (L)
AGAP	N/A			14
BUN	8			17
GLUCOSE	225 (H)			99
CREATININE	2.02 (H)			2.44 (H)
TOTAL BILI	0.4			
BILI UNCON	0.5			
BILI CONJ	0.0			
CALCIUM	10.3			7.4 (L)
T PROTEIN	6.7			
ALBUMIN	4.0			
TROPONIN I	0.008			
LACT ACID		N/A	1.7	

	2/27/2012 13:40
ALK PHOS	68
ALT(SGPT)	169 (H)
AST(SGOT)	147 (H)
CK	522 (H)

CK-MB	2.1
CKMB INDEX	0.4
LIPASE	67

	2/27/2012 13:40
ACETAMINOP	<10 (A)
SALICYLATE	<10 (A)
ALCOHOL	<15

	2/27/2012 13:40
COLOR	Yellow
APPEARANCE	Hazy (A)
SP GRAVITY	1.013
PH	6.0
PROTEIN	10mg/dL (A)
GLU U QUAL	NORMAL
KETONES	5 mg/dL (A)
BILIRUBIN	NEGATIVE
BLOOD	TRACE (A)
UROBILIN	2.0mg/dL (A)
NITRITE	NEGATIVE
LEUK ESTER	NEGATIVE
RBC/HPF	6 (H)
WBC/HPF	1
BACTERIA	FEW (A)
SQ EPITH	1
MUCOUS	MODERATE (A)
SPERM	13

Drug screen positive for PCP, cocaine, THC
CXR: ETT and R IJ in place, no consolidation
Bedside TTE: Normal to hyperdynamic LVF, RV grossly normal size and function, no large pericardial effusion

CT HEAD W/O CONTRAST:
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IMPRESSION:

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The findings relayed to the clinical team at the time of dictation.

ASSESSMENT/PLAN:

CV
S/P Cardiac arrest
Pt with 2 episodes of cardiac arrest s/p taser x2 while intoxicated on PCP, cocaine, and THC. Assumed PEA, with ROSC within 5 minutes each time. Hypothermia protocol initiated in ER. Pt was severely acidotic on arrival to ER with significantly elevated lactic acid, poor prognosis
- admit to MICU
- mechanical ventilation
- continue hypothermia protocol
  - Pt cooled to 33 C (reached at approx 8 pm), maintain x 24 hours, then passive rewarming
  - BMP Q8hr
  - CBC Q8hr
  - Coags Q8hr
  - Serum glucose Q6hr, keep <200
  - Vital signs Q1hr
  - Avoid any motion of patient
  - Sedation protocol, RASS -4
  - Maintain MAP >90
- lactic acid Q8hr
- blood culture x 2, urine culture
- continue NS 150 cc/hr
- trend cardiac enzymes
- trend LFTs

Hypertension
Initially with hypotension and shock in ED following cardiac arrest that required pressors. BP has been significantly elevated since arrival to the MICU secondary to cerebral edema and vasoconstriction from hypothermia
- maintain MAP >90
- will try BZDs, sedation to slightly lower BP

Neuro
Cerebral edema and possible anoxic brain injury
CT scan in ER showed evidence of cerebral edema likely from ischemic injury. Pt showing no purposeful movements following resuscitation and currently undergoing hypothermia protocol

- continue neuro checks
- elevate HOB to 30 degree
- continue hypothermia protocol
- will assess further neurological function following rewarming

Renal
AKI
Likely intrinsic injury from decreased perfusion secondary to shock. Minimal UOP in ED but now improved
- monitor UOP and creatinine closely
- avoid nephrotoxic agents and renally dose all medications
- will consult nephrology if kidney function continues to deteriorate and HD is necessary, if family desires

GI
Hematemesis
Bloody fluid from OG tube, likely secondary to ischemic injury, DIC?
- protonix BID
- monitor CBC and coags Q8hr
- fibrinogen, d-dimer, FDP

Elevated LFTs
No known baseline, may be trending upwards secondary to ischemic injury and shock liver
- trend LFTs
- consider hepatitis panel

FEN
Hypokalemia- replace as needed
IVF- NS 150 cc/hr
Feeds- hold until hypothermia protocol completed

Prophylaxis
DVT: Hold, GI bleeding
Stress Ulcer: PPI
Code status: DNR, full interventions

JENNIFER L MCCRACKEN, MD 2/28/2012 12:59 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/28/12 0531

02/28/12 0143 H&P Addendum By Jennifer L McCracken, MD

H&P signed by Jennifer L McCracken, MD at 02/28/12 0143

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/28/12 0143	Note Time:	02/28/12 0028	Note Status:	Revised
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/28/12 0903				
	Addendum by: Jennifer L McCracken, MD filed at 02/28/12 0531 Original Note by: Jennifer L McCracken, MD filed at 02/28/12 0109				

Date of Service: 2/27/2012

CHIEF COMPLAINT:
S/p cardiac arrest

HPI
Patient is a 38 year old Black or African American male admitted from the ER s/p out of hospital cardiac arrest. Per EMS and police, pt had been exhibiting bizarre behavior and jumped off 2 story balcony. Police dry tazed him twice at which time he became unresponsive and had no pulse. CPR was started, received epinephrine and he had ROSC in 5 minutes. He was intubated in the field. Upon arrival to UTMB, he again lost pulse and had CPR lasting 5 minutes with return of circulation. He initially required pressors due to hypotension but they were able to weaned off while in ER. Hypothermia protocol was initiated. Initial ABG showed severe acidosis with pH <6.6 and sodium bicarbonate drip was started. Also received 1 dose of vanc and zosyn. Drug screen positive for PCP, cocaine, and THC.

ALLERGY:
Review of patient's allergies indicates no known allergies.

HISTORIES
MEDICAL HISTORY:
None per family

SURGICAL HISTORY:
None per family

SOCIAL HISTORY:
+ drug abuse

FAMILY HISTORY:

No family history on file.

MEDICATIONS
Home Medications:
No prescriptions prior to admission

Hospital Medications:
Current facility-administered medications

Medication	Dose	Route	Frequency	Last Rate	Last Dose
• pantoprazole (PROTONIX) 40 mg in D5W piggyback	40 mg	IV Piggyback	Q12H		
• DOPamine 1.6 mg/ml 800 mg/500 mL (1,600 mcg/mL) infusion	15 mcg/kg/min	Intravenous	TITRATE		Last Dose: 10 mcg/kg/min at 02/27/12 1430
• NORepinephrine (LEVOPHED) 4 mg in D5W 250 mL infusion	0.05 mcg/kg/min	IV Infusion	CONTINUOUS		Last Dose: 0.05 mcg/kg/min at 02/27/12 1646

• NaCl 0.9% (NS) IV infusion		Intravenous	CONTINUOUS	150 mL/hr (02/27/12 1954)
• midazolam (VERSED) injection 2 mg	2 mg	IV Push	PRN - SEE INSTRUCTIONS	
• midazolam (VERSED) 50 mg in NaCl 0.9% (NS) infusion	1 mg/hr	IV Infusion	TITRATE	
• FENTanyl PF (SUBLIMAZE (P/F)) 50 mcg/mL injection 50 mcg	50 mcg	Slow IV Push	PRN - SEE INSTRUCTIONS	
• FENTanyl PF (SUBLIMAZE (P/F)) 2,500 mcg in NaCl 0.9% (NS) 250 mL infusion	25 mcg/hr	IV Infusion	TITRATE	

REVIEW OF SYMPTOMS
Unable to obtain

PHYSICAL EXAMINATION
BP 197/161 | Pulse 88 | Temp(Src) 32.7 °C (90.9 °F) (Bladder) | Resp 23 | Wt 100 kg (220 lb 7.4 oz) | SpO2 100%

Constitutional: unresponsive, intubated, GCS 3
HEENT: pupils 1 mm, nonresponsive, ETT in place
Neck: no bruit, R IJ in place
Cardiovascular: RRR, no murmurs appreciated
Respiratory: CTAB anteriorly
Gastrointestinal: soft, normoactive bowel sounds
Extremities: no cyanosis, clubbing or edema
Musculoskeletal: no joint swelling or deformities
Neurologic: comatose, GCS 3
Skin: no rashes or lesion

Review of data:

	2/27/2012 13:40
WBCx10^3	11.4 (H)
RBCx10^6	4.49
HGB	13.0 (L)
HCT	45.9
MCV	102.2 (H)
MCH	29.0
MCHC	28.3 (L)
RDW	13.8
PLTx10^3	234
MPV	12.5 (H)
GRAN%	45.7
LYMPH%	39.2
MONO%	8.9
EOS%	1.4
BASO%	0.2

GRAN#x10^3	5.21
LYMP#x10^3	4.5 (H)
MONO#x10^3	1.0 (H)
EOS#x10^3	0.2
BASO#x10^3	0.0

	2/27/2012 17:00
PH ART	7.32 (L)
PCO2 ART	42
PO2 ART	47 (L)
HCO3 ART	21 (L)
ARTERIAL BE	-5.1 (L)

	2/27/2012 13:40	2/27/2012 13:55	2/27/2012 20:23	2/27/2012 20:37
NA	154 (H)			141
K	5.4 (H)			2.7 (AA)
CL	107			105
CO2 TOTAL	<5			22 (L)
AGAP	N/A			14
BUN	8			17
GLUCOSE	225 (H)			99
CREATININE	2.02 (H)			2.44 (H)
TOTAL BILI	0.4			
BILI UNCON	0.5			
BILI CONJ	0.0			
CALCIUM	10.3			7.4 (L)
T PROTEIN	6.7			
ALBUMIN	4.0			
TROPONIN I	0.008			
LACT ACID		N/A	1.7	

	2/27/2012 13:40
ALK PHOS	68
ALT(SGPT)	169 (H)
AST(SGOT)	147 (H)
CK	522 (H)
CK-MB	2.1
CKMB INDEX	0.4
LIPASE	67

	2/27/2012 13:40

ACETAMINOP	<10 (A)
SALICYLATE	<10 (A)
ALCOHOL	<15

	2/27/2012 13:40
COLOR	Yellow
APPEARANCE	Hazy (A)
SP GRAVITY	1.013
PH	6.0
PROTEIN	10mg/dL (A)
GLU U QUAL	NORMAL
KETONES	5 mg/dL (A)
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JENNIFER L MCCRACKEN, MD 2/28/2012 12:59 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/28/12 0143

02/28/12 0109 H&P Signed By Jennifer L McCracken, MD

H&P signed by Jennifer L McCracken, MD at 02/28/12 0109

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/28/12 0109	Note Time:	02/28/12 0028	Note Status:	Revised
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/28/12 0903				
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Injection 50 mcg		Push	INSTRUCTIONS
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	2/27/2012 17:00

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IVF- NS 150 cc/hr
Feeds- hold until hypothermia protocol completed

Prophylaxis
DVT: Hold, GI bleeding
Stress Ulcer: PPI
Code status: FULL CODE

JENNIFER L MCCRACKEN, MD 2/28/2012 12:59 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/28/12 0109

Consults - Encounter Notes

Consults signed by Katherine S Ozenberger at 02/28/12 1612

Author:	Katherine S Ozenberger	Service:	(none)	Author Type:	PASTORAL CARE
Filed:	02/28/12 1612	Note Time:	02/28/12 1611		

Consult Orders:
1. Consult PS Pastoral Care [52556537] ordered by Jennifer L McCracken, MD at 02/28/12 0031

Visited with patient and family at bedside as requested. Family has good local congregational care. Family is utilizing faith for coping with pt's illness. Prayer with wife and printed materials for spiritual care. Will follow as pt and family and chaplain are available.

Signed by Katherine S Ozenberger on 02/28/12 1612

Consults signed by Christopher M Messenger, RD at 02/28/12 1243

Author:	Christopher M Messenger, RD	Service:	(none)	Author Type:	DIETITIAN
Filed:	02/28/12 1243	Note Time:	02/28/12 1017		

Consult Orders:
1. Consult PS Food and Nutrition - Adult [52556505] ordered by Jennifer L McCracken, MD at 02/28/12 0028

Nutrition Services Consult Note:

Reason(s) for Consult:
Nursing positive screen mechanism on admission for:
1.) Total Braden less than 15 AND Braden nutrition score 1 or less: Yes

Reason(s) for Admission:
Chief complaint(s) listed were s/p cardiac arrest. I have reviewed Dr. M cCracken's note under H&P for

additional information on the circumstances surrounding the patients admission, initial medical assessment, and plan(s) of care. The pt was brought to the ER s/p out of hospital cardiac arrest. Pt was tazed by police following bizarre behavior, pt became unresponsive an pulseless, CPR was started, transferred to the ER and again he lost pulse (abbreviated h/o circum stances prior to hospitalization).

Eval/Assessment:
Age:
38 years
Height:
1.78 m
Weight:
100 kg
BMI:
31.6 kg/m2 (class I obesity)
IBW for Ht (Hamwi method):
75.5 kg +/- 3.8 kg

Labs:
Results for FEBTWELVE, FOX (MRN 346705N) as of 2/28/2012 10:58

	2/27/2012 13:40	2/27/2012 20:37	2/28/2012 02:10	2/28/2012 02:15
PROTIME PATIENT				19.0 (H)
PT INR				1.6
WBCx10^3	11.4 (H)			40.7 (H)
RBCx10^6	4.49			5.79 (H)
HGB	13.0 (L)			16.8
HCT	45.9			49.1
RDW	13.8			13.2
PLTx10^3	234			193
NA	154 (H)	141		145
K	5.4 (H)	2.7 (AA)		3.1 (L)
CL	107	105		108
CO2 TOTAL	<5	22 (L)		17 (L)
AGAP	N/A	14		20 (H)
BUN	8	17		19
GLUCOSE	225 (H)	99		172 (H)
CREATININE	2.02 (H)	2.44 (H)		2.80 (H)
CALCIUM	10.3	7.4 (L)		7.4 (L)
MAGNESIUM				4.7 (W)
T.PROTEIN	6.7			7.7
ALBUMIN	4.0			4.4
TROPONIN I	0.008			1.390 (H)
LACT ACID			4.4 (H)	
ALK PHOS	68			162 (H)
ALT(SGPT)	169 (H)			388 (H)
AST(SGOT)	147 (H)			647 (W)
CK	522 (H)			>14,400 (A)
CK-MB	2.1			139.0 (H)
CKMB INDEX	0.4			N/A
LIPASE	67			

Additional data noted in the Epic EMR for this admission

Medications:
I have reviewed the currently orde red medications in the Epic EMR found under the medications and MAR

tabs.

Current Diet Order:
NPO

Calculated Daily Nutritional Needs:
Calories: 2025kcal/day = 20.3kcal/kg current wt = 26.8kcal/kg IBW
Protein: 18-20% of kcal need/day = 91-101g/day = 0.91-1g/kg current wt = 1.21-1.34g/kg IBW
Fluid: 2100-2400mL/day for hydration maintenance when euvolemic, adjust rec'd goal per pt acute needs

Opinion for Intervention(s):
1.) When the pt is hemodynamically stable and can tolerate volume recommend Osmolite started via DHT at 20mL/hr with a goal rate of 77mL/hr to deliver 2032kcal, 86g protein, 1552mL free water per 24hrs. Add 180mL enteral free water flushes x4/day
2.) If the pt's renal function is poor and sensitive to fluid overloading do not add the free water flushes in #1. If less than 1552mL free water/day is desired then opt for Suplena, 47mL/hr goal rate to deliver 2030kcal, 51g protein, 823mL free water per 24hrs at goal. Add additional free water as desired.

Plan for Evaluation:
Will F/U in 2-3 days to review the pt's chart, diet order, and reassess the pt's nutritional needs if necessary. Please page with questions or concerns, thank-you.

Chris Messenger RD,LD
Pager: 643-2815
RD Office: 29787, 29773

Signed by Christopher M Messenger, RD on 02/28/12 1243

Consults signed by Bronislawa Michejenko, GNP at 02/28/12 1026

Author:	Bronislawa Michejenko, GNP	Service:	(none)	Author Type:	MIDLEVEL PROVIDER
Filed:	02/28/12 1026	Note Time:	02/28/12 1020		

Consult Orders:
1. Consult PS CES / Specialty Beds [52550713] ordered by Marco A de Los Santos, MD at 02/27/12 1819

Consult for specialty bed. Ken Air. Critically ill 38 yr old male S/p cardiac arrest, on vasopressors and induced hypothermia. Braden 11. Ken Air approved.

Signed by Bronislawa Michejenko, GNP on 02/28/12 1026

Consults signed by Shawn P Nishi, MD at 02/27/12 2008

Author:	Shawn P Nishi, MD	Service:	(none)	Author Type:	STAFF
Filed:	02/27/12 2008	Note Time:	02/27/12 1431		
Related Notes:	Related Note by: Marco A de Los Santos, MD filed at 02/27/12 1556				

I personally examined the patient on 2/27/2012 and agree with Dr. DeLosSantos' note with the following addition(s):
Fox Febtwelve is a 38 year old male s/p code from taser while intoxicated with PCP, cocaine, THC. Comatose on arrival with ROSC <5 min x2 and initiated on hypothermia protocol. Goal 34 degrees C ASAP and maintain 24h -> passive rewarming to assess for neuro status. Prognosis poor in this setting given profound acidosis, MOF, and setting.

I actively participated in the decision-making process. Please see the fellow's note for additional details.

Signed by Shawn P Nishi, MD on 02/27/12 2008

Consults signed by Marco A de Los Santos, MD at 02/27/12 1555

Author:	Marco A de Los Santos, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/27/12 1555	Note Time:	02/27/12 1431		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/27/12 2008				
	Original Note by: Marco A de Los Santos, MD filed at 02/27/12 1546				

DEPARTMENT OF CRITICAL CARE CONSULT REPORT

Requesting Physician: RUMPH
DATE OF SERVICE: 2/27/2012
NAME: Fox Febtwelve
UH#: 346705N

Chief Complaint:
We were asked to see this patient to give my opinion regarding Fox Febtwelve, 38 year old, male who presents with PEA arrest and shock.

HPI
Patient is a 38 year old Black or African American male who presented after out of hospital arrest. Patient per reports experienced PEA arrest in the field and had CPR. Again per reports he had ROSC on the field in 5 minutes. Upon arriving at UTMB he lost pulse again and had CPR lasting 5 minutes with return of spontaeous circulation. I assessed patient after his second code and noted BP 60/20s. Right IJ was established and levaphed was started decreasing dopamine. Patient was intubated and non responsive. Blood pressure improved with a MAP of >60 on levaphed. He was found however to have a immesurable pH and Lactic acid. We had a family meeting >20 minutes and discussed his MOF.

ALLERGY:
Review of patient's allergies indicates no known allergies.

HISTORY

PAST MEDICAL HISTORY:
Drug abuse

SURGICAL HISTORY:
None per family

SOCIAL HISTORY:
Drug abuse

FAMILY HISTORY:
Unable to ask

MEDICATIONS:
Current facility-administered medications

Medication	Dose	Route	Frequency	Last Rate	Last Dose
• NaCl 0.9% (NS) bolus infusion 1,000 mL	1,000 mL	Intravenous	ONCE		
• DOPamine 1.6 mg/ml 800 mg/500 mL (1,600	15	Intravenous	TITRATE	56.25	Last Dose:

mcg/mL) infusion	mcg/kg/m in	us		mL/hr (02/27/12 1218)	15 mcg/kg/m in at 02/27/12 1218
• NORepinephrine (LEVOPHED) 4 mg in D5W 250 mL infusion	0.05 mcg/kg/m in	IV Infusion	CONTINUOUS	18.75 mL/hr (02/27/12 1320)	Last Dose: 0.05 mcg/kg/m in at 02/27/12 1320
• sodium bicarbonate 150 mEq in D5W 0.45% NaCl (1/2NS) 1,000 mL IV Solution		IV Infusion	CONTINUOUS		
• pantoprazole (PROTONIX) 40 mg in D5W piggyback	40 mg	IV Piggyback	Q24H		Last Dose: 40 mg at 02/27/12 1416
• pancuronium (PAVULON) injection 10 mg	10 mg	IV Push	ONCE		

No current outpatient prescriptions on file.

REVIEW OF SYMPTOMS
Unable to obtain

PHYSICAL EXAMINATION
Patient Vitals in the past 24 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2	Weight
02/27/12 1418	111/51 mmHg	-	-	132	-	100 %	-
02/27/12 1412	118/51 mmHg	35.4 °C (95.7 °F)	Bladder	133	22	98 %	-
02/27/12 1329	109/41 mmHg	-	-	130	-	100 %	-
02/27/12 1229	-	-	-	116	17	98 %	-
02/27/12 1214	-	-	-	-	-	-	100 kg (220 lb 7.4 oz)
02/27/12 1207	64/17 mmHg	-	-	97	20	71 %	-
02/27/12 1159	121/78 mmHg	-	-	107	-	100 %	-
02/27/12 1157	89/55 mmHg	-	-	120	20	100 %	-

Constitutional: Patient intubated comatose
Ears, Nose,Throat: normal nares, clear throat
Neck: supple, no lymphadenopathy
Cardiovascular: tachycardic

Respiratory: clear breath sounds bilaterally
Gastrointestinal: soft, non tender, no masses
Extremities: no cyanosis, clubbing or edema
Musculoskeletal: no joint swelling or deformities
Neurologic: comatose
Skin: no rashes or lesion

Review of Data:
Results for FEBTWELVE, FOX (MRN 346705N) as of 2/27/2012 15:26

	2/27/2012 13:40	2/27/2012 13:55
WBCx10^3	11.4 (H)	
RBCx10^6	4.49	
HGB	13.0 (L)	
HCT	45.9	
MCV	102.2 (H)	
MCH	29.0	
MCHC	28.3 (L)	
RDW	13.8	
PLTx10^3	234	
MPV	12.5 (H)	
RDWSD	51.6 (H)	
NA	154 (H)	
K	5.4 (H)	
CL	107	
CO2 TOTAL	<5	
AGAP	N/A	
BUN	8	
GLUCOSE	225 (H)	
CREATININE	2.02 (H)	
TOTAL BILI	0.4	
BILI UNCON	0.5	
BILI CONJ	0.0	
CALCIUM	10.3	
T PROTEIN	6.7	
ALBUMIN	4.0	
TROPONIN I	0.008	
LACT ACID		N/A
ALK PHOS	68	
ALT(SGPT)	169 (H)	
AST(SGOT)	147 (H)	
CK	522 (H)	
CK-MB	2.1	
CKMB INDEX	0.4	
LIPASE	67	
ACETAMINOP	<10 (A)	
ACETAMIN TLD	N/A (A)	

SALICYLATE	<10 (A)	
SALICYLATE TLD	N/A (A)	
ALCOHOL	<15	
SPEC TYPE	SERUM	
DRUG SCREEN PANEL 2	Rpt	
COLOR	Yellow	
APPEARANCE	Hazy (A)	
SP GRAVITY	1.013	
PH	6.0	
PROTEIN	10mg/dL (A)	
GLU U QUAL	NORMAL	
KETONES	5 mg/dL (A)	
BILIRUBIN	NEGATIVE	
BLOOD	TRACE (A)	
UROBILIN	2.0mg/dL (A)	
NITRITE	NEGATIVE	
LEUK ESTER	NEGATIVE	
RBC/HPF	6 (H)	
WBC/HPF	1	
BACTERIA	FEW (A)	
SQ EPITH	1	
MUCOUS	MODERATE (A)	
SPERM	13	

ASSESSMENT/PLAN:

Fox Febtwelve is a 38 year old male

CARDIAC ARREST/SHOCK
Patient with presumed PEA cardiac arrest X 2. ROSC was approximately (per reports) 5 minutes each time. Patient is critically ill and severely acidotic with an immensurable Lactic acid (>24). Patient has minimal urine output. This patient with MOF and shock has a poor prognosis. Although literature recommends hypothermia protocol for out of hospital VF/VT arrest in a comatose patient with a ROSC <30-60 minutes we believe patient would benefit from a reduction of his core temperature to aid in neurological recovery.

Induce hypothermia protocol

Apply cooling device and cool patient to 33°C

Respiratory therapy to turn heater off until patient reaches 33°C. Turn heater back on once patient reaches target temperature.

Check lactic acid q 6 hours

Nephrology consult for dialysis (if family desires)

Sedation and paralysis

Vital signs every 15 minutes.

Baseline ABG, CBC, electrolytes, BUN and creatinine, glucose; magnesium post ROSC; repeat 1 hour after initiation of hypothermia therapy.

Baseline lipase, amylase, LFT's, blood culture x2, UA with sensitivity and culture and sputum culture
Repeat ABG after paralysis/sedation achieved.
Electrolytes, BUN and creatinine, magnesium, glucose, and ABG every 6-8 hours
Maintain MAP ≥ 70mmHg
Glucose Control <200

M A De Los Santos #9308
Pulmonary/Critical Care
PGY5
pgr 643-0650

Signed by Marco A de Los Santos, MD on 02/27/12 1555

02/27/12 1546 Consults Signed By Marco A de Los Santos, MD

Consults signed by Marco A de Los Santos, MD at 02/27/12 1546

Author:	Marco A de Los Santos, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/27/12 1546	Note Time:	02/27/12 1431	Note Status:	Revised
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/27/12 2008				
	Addendum by: Marco A de Los Santos, MD filed at 02/27/12 1555				

DEPARTMENT OF CRITICAL CARE
CONSULT REPORT

Requesting Physician: RUMPH
DATE OF SERVICE: 2/27/2012
NAME: Fox Febtwelve
UH#: 346705N

Chief Complaint:
We were asked to see this patient to give my opinion regarding Fox Febtwelve, 38 year old, male who presents with PEA arrest and shock.

HPI
Patient is a 38 year old Black or African American male who presented after out of hospital arrest. Patient per reports experienced PEA arrest in the field and had CPR. Again per reports he had ROSC on the field in 5 minutes. Upon arriving at UTMB he lost pulse again and had CPR again for about 5 minutes with return of sponaneious circulation. Upon arrival patient BP 60/20s. Right IJ was established by myself and levaphed was started.

ALLERGY:
Review of patient's allergies indicates no known allergies.

HISTORY

PAST MEDICAL HISTORY:
Drug abuse

SURGICAL HISTORY:
None per family

SOCIAL HISTORY:
Drug abuse

FAMILY HISTORY:
Unable to ask

MEDICATIONS:
Current facility-administered medications

Medication	Dose	Route	Frequency	Last Rate	Last Dose
• NaCl 0.9% (NS) bolus infusion 1,000 mL	1,000 mL	Intravenous	ONCE		
• DOPamine 1.6 mg/ml 800 mg/500 mL (1,600 mcg/mL) infusion	15 mcg/kg/min	Intravenous	TITRATE	56.25 mL/hr (02/27/12 1218)	Last Dose: 15 mcg/kg/min at 02/27/12 1218
• NORepinephrine (LEVOPHED) 4 mg in D5W 250 mL infusion	0.05 mcg/kg/min	IV Infusion	CONTINUOUS	18.75 mL/hr (02/27/12 1320)	Last Dose: 0.05 mcg/kg/min at 02/27/12 1320
• sodium bicarbonate 150 mEq in D5W 0.45% NaCl (1/2NS) 1,000 mL IV Solution		IV Infusion	CONTINUOUS		
• pantoprazole (PROTONIX) 40 mg in D5W piggyback	40 mg	IV Piggyback	Q24H		Last Dose: 40 mg at 02/27/12 1416
• pancuronium (PAVULON) injection 10 mg	10 mg	IV Push	ONCE		

No current outpatient prescriptions on file.

REVIEW OF SYMPTOMS
Unable to obtain

PHYSICAL EXAMINATION
Patient Vitals in the past 24 hrs:

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02/27/12 1329	109/41 mmHg	-	-	130	-	100 %	-
02/27/12 1229	-	-	-	116	17	98 %	-
02/27/12	-	-	-	-	-	-	100 kg (220 lb

1214							7.4 oz)
02/27/12 1207	64/17 mmHg	-	-	97	20	71 %	-
02/27/12 1159	121/78 mmHg	-	-	107	-	100 %	-
02/27/12 1157	89/55 mmHg	-	-	120	20	100 %	-

Constitutional: Patient intubated comatose
Ears, Nose,Throat: normal nares, clear throat
Neck: supple, no lymphadenopathy
Cardiovascular: tachycardic
Respiratory: clear breath sounds bilaterally
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Skin: no rashes or lesion

Review of Data:
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AGAP	N/A	
BUN	8	
GLUCOSE	225 (H)	
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BILI UNCON	0.5	
BILI CONJ	0.0	
CALCIUM	10.3	
T PROTEIN	6.7	
ALBUMIN	4.0	
TROPONIN I	0.008	

LACT ACID		N/A
ALK PHOS	68	
ALT(SGPT)	169 (H)	
AST(SGOT)	147 (H)	
CK	522 (H)	
CK-MB	2.1	
CKMB INDEX	0.4	
LIPASE	67	
ACETAMINOP	<10 (A)	
ACETAMIN TLD	N/A (A)	
SALICYLATE	<10 (A)	
SALICYLATE TLD	N/A (A)	
ALCOHOL	<15	
SPEC TYPE	SERUM	
DRUG SCREEN PANEL 2	Rpt	
COLOR	Yellow	
APPEARANCE	Hazy (A)	
SP GRAVITY	1.013	
PH	6.0	
PROTEIN	10mg/dL (A)	
GLU U QUAL	NORMAL	
KETONES	5 mg/dL (A)	
BILIRUBIN	NEGATIVE	
BLOOD	TRACE (A)	
UROBILIN	2.0mg/dL (A)	
NITRITE	NEGATIVE	
LEUK ESTER	NEGATIVE	
RBC/HPF	6 (H)	
WBC/HPF	1	
BACTERIA	FEW (A)	
SQ EPITH	1	
MUCOUS	MODERATE (A)	
SPERM	13	

ASSESSMENT/PLAN:

Fox Febtwelve is a 38 year old male

CARDIAC ARREST/SHOCK
Patient with presumed PEA cardiac arrest X 2. ROSC was approximately (per reports) 5 minutes each time. Patient is critically ill and severely acidotic with an immensurable Lactic acid (>24). Patient has minimal urine output. This patient with MOF and shock has a poor prognosis. Although literature recommends hypothermia protocol for out of hospital VF/VT arrest in a comatose patient with a ROSC <30-60 minutes we believe patient

would benefit from a reduction of his core temperature to aid in neurological recovery.

Induce hypothermia protocol

Apply cooling device and cool patient to 33°C

Respiratory therapy to turn heater off until patient reaches 33°C. Turn heater back on once patient reaches target temperature.

Check lactic acid q 6 hours

Nephrology consult for dialysis (if family desires)

Sedation and paralysis

Vital signs every 15 minutes.

Baseline ABG, CBC, electrolytes, BUN and creatinine, glucose; magnesium post ROSC; repeat 1 hour after initiation of hypothermia therapy.

Baseline lipase, amylase, LFT's, blood culture x2, UA with sensitivity and culture and sputum culture

Repeat ABG after paralysis/sedation achieved.

Electrolytes, BUN and creatinine, magnesium, glucose, and ABG every 6-8 hours

Maintain MAP ≥ 70mmHg

Glucose Control <200

M A De Los Santos #9308
Pulmonary/Critical Care
PGY5
pgr 643-0650

Signed by Marco A de Los Santos, MD on 02/27/12 1646

Procedures - Encounter Notes

Procedures signed by Shiwan Shah, DO at 02/27/12 2235

Author:	Shiwan Shah, DO	Service:	(none)	Author Type:	STAFF
Filed:	02/27/12 2235	Note Time:	02/27/12 1700		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/28/12 0821				

Pre-procedure Diagnoses
1. CARDIAC ARREST (427.5)
2. SHOCK (785.50)

Post-procedure Diagnoses
1. CARDIAC ARREST (427.5)
2. SHOCK (785.50)

Procedures
1. ECHO HEART XTHORACIC,LIMITED (93308)

Critical Care Echocardiogram

Views: Parasternal short axis, parasternal long axis, subcostal

Findings:

1. Normal to hyperdynamic left ventricular function
2. Right ventricle grossly normal size and function
3. No large pericardial effusion

M-MODE Parasternal Long Axis showing good fractional shortening

Shiwan Kamal Shah DO
Pulmonary Critical Care Fellow
Pager: 409-942-6222, Dr. # 8875

Signed by Shiwan Shah, DO on 02/27/12 2235

Procedures signed by Marco A de Los Santos, MD at 02/27/12 1255

Author:	Marco A de Los Santos, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/27/12 1255	Note Time:	02/27/12 1253		

Pre-procedure Diagnoses
1. HYPOTENSION (458)

Post-procedure Diagnoses
1. HYPOTENSION (458)

Procedures
1. CENTRAL VENOUS ACCESS CATHETER PLACEMENT (ORP000259)

CENTRAL LINE PLACEMENT

Date of Service: 2/27/2012

Faculty: NISHI
Credentialed supervisor: SELF

Indication/Diagnosis: pressors

Consent: emergent procedure

PreProcedure Verification Completed: yes
Site Marking Completed yes
Time Out was Performed According to Checklist: yes.

Sterile technique was used : A cap and mask were donned, hand hygiene was performed and sterile gown and gloves were donned. The skin was prepped with 2% chlorhexidine and the solution was allowed to dry. A full body fenestrated drape was placed over the patient without contaminating the drape during placement.

Anesthesia: none

Instrument(s) type: triple lumen catheter

Procedure site: right internal jugular vein

Sterile dressing: yes

Narrative:

Patient was prepped and draped in the usual sterile fashion. A central line was introduced with the Seldinger technique into the right right internal jugular vein after one attempts. Guide wire was threaded without difficulty. The catheter was then placed over the guide wire, the guide wire was removed, and the catheter was sutured into place. Good flow was noted from the port(s) and the catheter flushed easily. Blood loss was

minimal.

Complications: none

Chest x-ray: cleared

Dr. Nishi, Faculty, was present for the entire procedure.

M A De Los Santos #9308
Pulmonary/Critical Care
PGY5
pgr 643-0650

Signed by Marco A de Los Santos, MD on 02/27/12 1255

Progress Notes - Encounter Notes

Progress Notes signed by Jennifer L McCracken, MD at 02/29/12 2247

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 2247	Note Time:	02/29/12 0423		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 03/01/12 0751				
	Original Note by: Jennifer L McCracken, MD filed at 02/29/12 0631				

Date of Service: 2/29/12

Time: 4:41 AM **ICU Day #:** 3 **Intubation Day #:** 3

Reason for ICU admission: s/p cardiac arrest, cerebral edema, likely anoxic brain injury
Code Status: DNR, full interventions
Last 24 hour events:
- began passive rewarming
- given 300 mL of 3% hypertonic saline IV for cerebral edema
- replaced K
- levophed at 0.16
- became more tachycardic overnight
- creatinine and LFTs continue to increase
- CK remains significantly elevated

Ventilator Bundle:
Sedation/Analgesia: none
Stress ulcer prophylaxis: PPI
DVT prophylaxis: contraindicated

Physical Exam:

Patient Vitals in the past 24 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2
02/29/12 0400	149/71 mmHg	36.4 °C (97.5 °F)	Bladder	-	18	100 %
02/29/12 0215	119/59 mmHg	-	-	-	18	100 %
02/29/12 0200	108/74 mmHg	36.7 °C (98.1 °F)	Bladder	-	18	100 %
02/29/12 0145	129/59 mmHg	36.7 °C (98.1 °F)	Bladder	-	18	100 %
02/29/12 0100	165/109 mmHg	36.5 °C (97.7 °F)	Bladder	-	18	100 %
02/29/12 0050	-	-	-	134	18	99 %
02/29/12 0000	180/101 mmHg	35.8 °C (96.4 °F)	Bladder	-	18	100 %

02/28/12 2300	140/91 mmHg	35 °C (95 °F)	Bladder	-	18	100 %
02/28/12 2200	116/75 mmHg	34.1 °C (93.4 °F)	Bladder	-	18	100 %
02/28/12 2100	145/87 mmHg	33.1 °C (91.6 °F)	Bladder	-	18	100 %
02/28/12 2000	146/87 mmHg	33 °C (91.4 °F)	Bladder	-	18	100 %
02/28/12 1908	-	-	-	69	18	100 %
02/28/12 1900	149/88 mmHg	33 °C (91.4 °F)	Bladder	-	18	100 %
02/28/12 1800	126/76 mmHg	33.3 °C (91.9 °F)	Bladder	-	18	-
02/28/12 1700	133/83 mmHg	32.8 °C (91 °F)	Bladder	-	18	-
02/28/12 1600	122/80 mmHg	32.6 °C (90.7 °F)	Bladder	-	18	100 %
02/28/12 1530	-	32.5 °C (90.5 °F)	Bladder	-	-	-
02/28/12 1500	132/85 mmHg	32.4 °C (90.3 °F)	Bladder	-	18	100 %
02/28/12 1430	-	32.2 °C (90 °F)	Bladder	-	-	-
02/28/12 1400	135/85 mmHg	32 °C (89.6 °F)	Bladder	-	18	100 %
02/28/12 1330	-	31.9 °C (89.4 °F)	Bladder	-	-	-
02/28/12 1300	146/97 mmHg	31.8 °C (89.2 °F)	Bladder	-	18	100 %
02/28/12 1200	146/92 mmHg	31.5 °C (88.7 °F)	Bladder	-	18	100 %
02/28/12 1145	-	-	-	75	18	100 %
02/28/12 1130	-	31.4 °C (88.5 °F)	Bladder	-	-	-
02/28/12 1100	154/102 mmHg	31.3 °C (88.3 °F)	Bladder	-	18	100 %
02/28/12 1030	-	31.2 °C (88.2 °F)	Bladder	-	-	-
02/28/12 1000	160/92 mmHg	31.3 °C (88.3 °F)	Bladder	-	18	100 %
02/28/12 0900	159/97 mmHg	32.2 °C (90 °F)	Bladder	-	18	100 %
02/28/12 0800	159/88 mmHg	31.6 °C (88.9 °F)	Bladder	-	14	100 %
02/28/12 0700	155/92 mmHg	31.9 °C (89.4 °F)	Bladder	-	14	100 %
02/28/12 0621	-	-	-	-	14	100 %
02/28/12 0600	148/87 mmHg	32.3 °C (90.1 °F)	Bladder	-	14	100 %

Tmax/Tcurrent: 36.4/36.4 C **HR:** 64-134 **BP:** 108-180/59-102 **RR:** 14-18 **I&O:** 6365/2054 **UO:**81 ml/kg/hr
Vent: PRVC, rate 18, Vt 550, PEEP 5, FIO2 60
Pressors (mcg/kg/min): norephinephrine: 0.16

General Appearance: unresponsive, intubated
HEENT: L pupil 6 mm, R pupil 8 mm, nonresponsive to light, no corneal reflex. ETT in place
Lungs: CTAB
Cardiovascular: tachycardia, normal S1, S2, no murmurs appreciated
Abdomen: soft, nondistended, hypoactive bowel sounds
Extremities: no clubbing, cyanosis, edema
Neuro: unresponsive, no corneal reflex
Skin: + tattoos

Labs:

	2/29/2012 00:45
WBCx10^3	25.8 (H)
RBCx10^6	4.97
HGB	14.4
HCT	42.1
MCV	84.7
MCH	29.0
MCHC	34.2

RDW	13.5
PLTx10^3	144 (L)
MPV	11.2

	2/29/2012 00:45
NA	147 (H)
K	3.3 (L)
CL	120 (H)
CO2 TOTAL	14 (L)
AGAP	13
BUN	22
GLUCOSE	78
CREATININE	3.60 (H)
CALCIUM	7.2 (L)
MAGNESIUM	3.1 (H)
LACT ACID	1.4

	2/29/2012 00:45
TROPONIN I	0.743 (H)
LACT ACID	1.4
ALK PHOS	117
ALT(SGPT)	628 (H)
AST(SGOT)	1013 (W)
CK	>14,400 (A)
CK-MB	231.0 (H)

Assessment/Plan:

CV

S/P Cardiac arrest

Pt with 2 episodes of cardiac arrest s/p taser x2 while intoxicated on PCP, cocaine, and THC. Assumed PEA, with ROSC within 5 minutes each time. Hypothermia protocol initiated in ER but now being rewarmed to assess neuro status.

- passive rewarming, goal 36 C by AM
- mechanical ventilation
- BMP Q4hr
- CBC Q8hr
- Coags Q8hr
- Serum glucose Q6hr, keep <200
- Vital signs Q1hr
- Sedation protocol, RASS -4
- Maintain MAP >90

- lactic acid Q8hr
- f/u blood and urine culture
- continue 1/2NS 250 cc/hr
- trend cardiac enzymes
- trend LFTs

Hypotension

Initially with hypotension and cardiogenic shock in ED following cardiac arrest that required pressors. Then admitted to the ICU with extreme hypertension. Pt acutely dropped BP night of admission and has required pressors since that time.

- maintain MAP >90
- levophed at 0.16

Neuro

Cerebral edema and possible anoxic brain injury

CT scan in ER showed evidence of cerebral edema likely from ischemic injury. Since arrival to unit, pt has developed dilated, unequal pupils, no corneal reflex, and no spontaneous respirations suggestive of herniation

- s/p 300 mL of hypertonic saline
- continue neuro checks
- elevate HOB to 30 degree
- rewarming started, goal of 36 C in AM in order to perform apnea test

Renal

AKI

Likely intrinsic injury from decreased perfusion secondary to shock. UOP decreasing

- monitor UOP and creatinine closely
- avoid nephrotoxic agents and renally dose all medications

Rhabdomyolysis

CK elevated >14,400 s/p taser and CPR, likely contributing to decreasing renal function

- continue 1/2NS 250 cc/hr
- monitor UOP

GI

Hematemesis

Bloody fluid from OG tube, likely secondary to ischemic injury, DIC?

- protonix BID
- monitor CBC and coags Q8hr

Elevated LFTs

No known baseline, trending upwards secondary to ischemic injury and shock liver

- trend LFTs

FEN

Hypokalemia- replace as needed

IVF- 1/2NS 250 cc/hr

Feeds- hold until hypothermia protocol completed

Prophylaxis

DVT: Hold, GI bleeding

Stress Ulcer: PPI

Code status: DNR, full interventions

JENNIFER L MCCRACKEN, MD 2/29/2012 4:42 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/29/12 2247

02/29/12 0631 Progress Notes Signed By Jennifer L McCracken, MD

Progress Notes signed by Jason Bennett Welch, DO at 02/29/12 1635

Author:	Jason Bennett Welch, DO	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 1635	Note Time:	02/29/12 1633		
Related Notes:	Original Note by: Jason Bennett Welch, DO filed at 02/29/12 1635				

2/29/2012 16:33

After Mr. Allen's death I was notified by the medical examiner that the body will be taken by Carnes Funeral home to Texas City for autopsy. I attempted to contact Raymond Allen Sr., his father, but was unsuccessful. We notified the patient's wife by phone that the body would not be sent to ER Johnson funeral home as initially requested, but to Texas City for autopsy instead and she voiced understanding of this.

Signed by Jason Bennett Welch, DO on 02/29/12 1635

02/29/12 1635 Progress Notes Signed By Jason Bennett Welch, DO

Progress Notes signed by Jason Bennett Welch, DO at 02/29/12 1635

Author:	Jason Bennett Welch, DO	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 1635	Note Time:	02/29/12 1633	Note Status:	Revised
Related Notes:	Addendum by: Jason Bennett Welch, DO filed at 02/29/12 1636				

2/29/2012 16:33

After mister Allen's death I was notified by the medical examiner that the body will be taken by Carnes Funeral home to Texas City for autopsy. I attempted to contact Raymond Allen Sr., his father, but was unsuccessful. We notified the patient's wife by phone that the body would not be sent to ER Johnson funeral home as initially requested, but to Texas City for autopsy instead and she voiced understanding of this.

Signed by Jason Bennett Welch, DO on 02/29/12 1635

Progress Notes signed by Jason Bennett Welch, DO at 02/29/12 1600

Progress Notes - Encounter Notes (continued)

Progress Notes signed by Jason Bennett Welch, DO at 02/29/12 1600 (continued)

Author:	Jason Bennett Welch, DO	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 1600	Note Time:	02/29/12 1540		
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/29/12 1610				

DEATH NOTE

Date of Service: 2/29/2012

Floor/Bed: 4A Bed 2
Service: MICU
CODE status: Do Not Resuscitate/Comfort Measures
Next of kin notified: yes: present at time of death in person

Fox Febtwelve is a 38 year old male with the PMH listed below was admitted to UTMB on 2/27/2012 for s/p cardiac arrest, cerebral edema, anoxic brain injury.

No past medical history on file.

I was at bedside at time of withdrawal of care. At 15:33 patient expired.

Physical exam revealed:
Patient was without heart tones by auscultation for 2 minutes.
Patient was without any respiration for 5 minutes.
Patient was without pupillary light response and eyes fixed gaze.
Patient was without response to verbal or noxious stimuli.

Patient was pronounced deceased at 15:33. Autopsy was not authorized by deciding family member: father Raymond Allen Sr.

Presumed cause of death: prolonged hypoxemia causing anoxic brain injury

Signed by Jason Bennett Welch, DO on 02/29/12 1600

Progress Notes signed by Shawn P Nishi, MD at 02/29/12 0801

Author:	Shawn P Nishi, MD	Service:	(none)	Author Type:	STAFF
Filed:	02/29/12 0801	Note Time:	02/29/12 0423		
Related Notes:	Related Note by: Jennifer L McCracken, MD filed at 02/29/12 0831				

I have also reviewed the progress note by Dr. McCracken and I agree with the history, physical examination, assessment and plan from 2/29/12.

Fox Febtwelve is a 38 year old male s/p code from taser while intoxicated with PCP, cocaine, THC. Comatose on arrival with ROSC <5 min x2 and initiated on hypothermia protocol.

-s/p hypothermia with rewarming this am

-overall no change in mentation or improvement in neuro exam

-pending apnea test this am and family discussion

Prognosis poor in this setting

I spent 30 minute(s) on date 2/29/2012 personally caring for this critically ill patient on the unit/floor.

The patient was critically ill due to Acute Renal Failure, Drug Overdose, Hepatic Failure, Metabolic Acidosis, Respiratory Failure, Shock/Hemodynamic Instability, Other: neuro failure.

I performed the following services: direct hands-on care of the patient, reviewed imagine studies and reviewed test results and interpretation of physiologic parameters.

Signed by Shawn P Nishi, MD on 02/29/12 0801

Progress Notes signed by Jennifer L McCracken, MD at 02/29/12 0631

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/29/12 0631	Note Time:	02/29/12 0423	Note Status:	Revised
Related Notes:	Cosigned by: Shawn P Nishi, MD filed at 02/29/12 0801				
	Addendum by: Jennifer L McCracken, MD filed at 02/29/12 2247				

Date of Service: 2/29/12

Time: 4:41 AM **ICU Day #:** 3 **Intubation Day #:** 3

Reason for ICU admission: s/p cardiac arrest, cerebral edema, likely anoxic brain injury
Code Status: DNR, full interventions
Last 24 hour events:
- began passive rewarming
- given 300 mL of 3% hypertonic saline IV for cerebral edema
- replaced K
- levophed at 0.16
- became more tachycardic overnight
- creatinine and LFTs continue to increase
- CK remains significantly elevated

Ventilator Bundle:
Sedation/Analgesia: none
Stress ulcer prophylaxis: PPI
DVT prophylaxis: contraindicated

Physical Exam:

Patient Vitals in the past 24 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2
02/29/12 0400	149/71 mmHg	36.4 °C (97.5 °F)	Bladder	-	18	100 %
02/29/12 0215	119/59 mmHg	-	-	-	18	100 %
02/29/12 0200	108/74 mmHg	36.7 °C (98.1 °F)	Bladder	-	18	100 %
02/29/12 0145	129/59 mmHg	36.7 °C (98.1 °F)	Bladder	-	18	100 %
02/29/12 0100	165/109 mmHg	36.5 °C (97.7 °F)	Bladder	-	18	100 %
02/29/12 0050	-	-	-	134	18	99 %
02/29/12 0000	180/101 mmHg	35.8 °C (96.4 °F)	Bladder	-	18	100 %
02/28/12 2300	140/91 mmHg	35 °C (95 °F)	Bladder	-	18	100 %
02/28/12 2200	116/75 mmHg	34.1 °C (93.4 °F)	Bladder	-	18	100 %
02/28/12 2100	145/87 mmHg	33.1 °C (91.6 °F)	Bladder	-	18	100 %
02/28/12 2000	146/87 mmHg	33 °C (91.4 °F)	Bladder	-	18	100 %
02/28/12 1908	-	-	-	69	18	100 %
02/28/12 1900	149/88 mmHg	33 °C (91.4 °F)	Bladder	-	18	100 %
02/28/12 1800	126/76 mmHg	33.3 °C (91.9 °F)	Bladder	-	18	-
02/28/12 1700	133/83 mmHg	32.8 °C (91 °F)	Bladder	-	18	-
02/28/12 1600	122/80 mmHg	32.6 °C (90.7 °F)	Bladder	-	18	100 %
02/28/12 1530						

	-	32.5 °C (90.5 °F)	Bladder	-	-	-
02/28/12 1500	132/85 mmHg	32.4 °C (90.3 °F)	Bladder	-	18	100 %
02/28/12 1430	-	32.2 °C (90 °F)	Bladder	-	-	-
02/28/12 1400	135/85 mmHg	32 °C (89.6 °F)	Bladder	-	18	100 %
02/28/12 1330	-	31.9 °C (89.4 °F)	Bladder	-	-	-
02/28/12 1300	146/97 mmHg	31.8 °C (89.2 °F)	Bladder	-	18	100 %
02/28/12 1200	146/92 mmHg	31.5 °C (88.7 °F)	Bladder	-	18	100 %
02/28/12 1145	-	-	-	75	18	100 %
02/28/12 1130	-	31.4 °C (88.5 °F)	Bladder	-	-	-
02/28/12 1100	154/102 mmHg	31.3 °C (88.3 °F)	Bladder	-	18	100 %
02/28/12 1030	-	31.2 °C (88.2 °F)	Bladder	-	-	-
02/28/12 1000	160/92 mmHg	31.3 °C (88.3 °F)	Bladder	-	18	100 %
02/28/12 0900	159/97 mmHg	32.2 °C (90 °F)	Bladder	-	18	100 %
02/28/12 0800	159/88 mmHg	31.6 °C (88.9 °F)	Bladder	-	14	100 %
02/28/12 0700	155/92 mmHg	31.9 °C (89.4 °F)	Bladder	-	14	100 %
02/28/12 0621	-	-	-	-	14	100 %
02/28/12 0600	148/87 mmHg	32.3 °C (90.1 °F)	Bladder	-	14	100 %

Tmax/Tcurrent: 36.4/36.4 C **HR:** 64-134 **BP:** 108-180/59-102 **RR:** 14-18 **I&O:** 6365/2054 **UO:**81 ml/kg/hr
Vent: PRVC, rate 18, Vt 550, PEEP 5, FIO2 60
Pressors (mcg/kg/min): norephinephrine: 0.16

General Appearance: unresponsive, intubated
HEENT: L pupil 6 mm, R pupil 8 mm, nonresponsive to light, no corneal reflex. ETT in place
Lungs: CTAB
Cardiovascular: tachycardia, normal S1, S2, no murmurs appreciated
Abdomen: soft, nondistended, hypoactive bowel sounds
Extremities: no clubbing, cyanosis, edema
Neuro: unresponsive, no corneal reflex
Skin: + tattoos

Labs:

	2/29/2012 00:45
WBCx10^3	25.8 (H)
RBCx10^6	4.97
HGB	14.4
HCT	42.1
MCV	84.7
MCH	29.0
MCHC	34.2
RDW	13.5
PLTx10^3	144 (L)
MPV	11.2

	2/29/2012 00:45
NA	147 (H)

K	3.3 (L)
CL	120 (H)
CO2 TOTAL	14 (L)
AGAP	13
BUN	22
GLUCOSE	78
CREATININE	3.60 (H)
CALCIUM	7.2 (L)
MAGNESIUM	3.1 (H)
LACT ACID	1.4

	2/29/2012 00:45
TROPONIN I	0.743 (H)
LACT ACID	1.4
ALK PHOS	117
ALT(SGPT)	628 (H)
AST(SGOT)	1013 (W)
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CK-MB	231.0 (H)

Assessment/Plan:

CV

S/P Cardiac arrest

Pt with 2 episodes of cardiac arrest s/p taser x2 while intoxicated on PCP, cocaine, and THC. Assumed PEA, with ROSC within 5 minutes each time. Hypothermia protocol initiated in ER but now being rewarmed to assess neuro status.

- passive rewarming, goal 36 C by AM
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- Vital signs Q1hr
- Sedation protocol, RASS -4
- Maintain MAP >90
- lactic acid Q8hr
- f/u blood and urine culture
- continue 1/2NS 250 cc/hr
- trend cardiac enzymes
- trend LFTs

Hypotension

Initially with hypotension and shock in ED following cardiac arrest that required pressors. Then admitted to the ICU with extreme hypertension. Pt acutely dropped BP night of admission and has required pressors since that time.

- maintain MAP >90
- levophed at 0.16

Neuro

Cerebral edema and possible anoxic brain injury

CT scan in ER showed evidence of cerebral edema likely from ischemic injury. Since arrival to unit, pt has developed dilated, unequal pupils, no corneal reflex, and no spontaneous respirations suggestive of herniation

- s/p 300 mL of hypertonic saline
- continue neuro checks
- elevate HOB to 30 degree
- rewarming started, goal of 36 C in AM in order to perform apnea test

Renal

AKI

Likely intrinsic injury from decreased perfusion secondary to shock. UOP decreasing

- monitor UOP and creatinine closely
- avoid nephrotoxic agents and renally dose all medications

Rhabdomyolysis

CK elevated >14,400 s/p taser and CPR, likely contributing to decreasing renal function

- continue 1/2NS 250 cc/hr
- monitor UOP

GI

Hematemesis

Bloody fluid from OG tube, likely secondary to ischemic injury, DIC?

- protonix BID
- monitor CBC and coags Q8hr

Elevated LFTs

No known baseline, trending upwards secondary to ischemic injury and shock liver

- trend LFTs

FEN

Hypokalemia- replace as needed

IVF- 1/2NS 250 cc/hr

Feeds- hold until hypothermia protocol completed

Prophylaxis

DVT: Hold, GI bleeding

Stress Ulcer: PPI

Code status: DNR, full interventions

JENNIFER L MCCRACKEN, MD 2/29/2012 4:42 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/29/12 0631

Progress Notes signed by Haitham T Shaheen, MBBS at 02/28/12 2013

Author:	Haitham T Shaheen, MBBS	Service:	(none)	Author Type:	RESIDENT
Filed:	02/28/12 2013	Note Time:	02/28/12 1957		

MICU Update Note

2/28/2012 19:57

Major Medical Issues:
Post cardiac arrest
Cerebral edema and possible anoxic brain injury
AKI

12hr events:
Given 300 ml of 3% hypertonic saline IV for cerebral edema
Still being rewarmed, now being actively rewarmed
Family was updated about current patient condition and plan for rewarming and apnea test later.

Next 12hrs:
Continue rewarming to 36 degrees
Apnea test in AM

Ventilator Bundle:
Sedation/Analgesia: none
Stress ulcer prophylaxis: PPI
Vent: PRVC/AC: rate 18, Vt 550, PEEP 5, FIO2 60
Pressors (mcg/kg/min): norephinephrine

Code Status: DNR, FULL intervention

Signed by Haitham T Shaheen, MBBS on 02/28/12 2013

Progress Notes signed by Jennifer L McCracken, MD at 02/28/12 0313

Author:	Jennifer L McCracken, MD	Service:	(none)	Author Type:	RESIDENT
Filed:	02/28/12 0313	Note Time:	02/28/12 0310		

MICU Progress Note

Pt had been hypertensive since arrival to unit reaching as high as 250s/140s. Situation was discussed with Dr. Shah and the thought was to start on nitro drip. Upon recheck of BP, it had decreased to 150s/110 with titration of sedation to

Progress Notes - Encounter Notes (continued)

fentanyl 100 and versed 4. The nurse notified me 10 minutes later that BP dropped to 60/40s so sedation was stopped and BP was observed for improvement. His BP remained stable at 60/40s so levaphed was started and will be titrated to keep MAP >90. Wife was at bedside and updated on condition.

JENNIFER L MCCRACKEN, MD 2/28/2012 3:12 AM
#10454
PGY-2 Internal Medicine
Pager 645-5323

Signed by Jennifer L McCracken, MD on 02/28/12 0313

Health

IMAGING - Clinical Orders

CT HEAD W/O CONTRAST [525496B3] — Signed

Entered by:	Siva Krishna Mannem, MBBS 02/27/12 1714	Ordered by:	Siva Krishna Mannem, MBBS
Authorized by:	Siva Krishna Mannem, MBBS	Frequency:	ONCE 02/27/12 1715 -1 Occurrences
Electronically signed by:	Siva Krishna Mannem, MBBS 02/27/12 1714		
Diagnoses:	CARDIAC ARREST [427.5]		
Questions:	Diabetic: No Isolation: None Transport With: IV/Pump, O2, Tube/Drain, Vent Patient's Weight: 100 kg (220 lb 7.4 oz) Transport Method: Stretcher		

Comments:
S/SX, Dx: Fox Febtwelve is a 36 year old male presented with cardiac arrest s/p CPR now intubated,please evaluate

CHEST 1 VIEW [52539708] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 -1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		
Questions:	Portable Exam: ED		

Comments:
S/SX, Dx: cardiac arrest, intubation

Health

LAB - Clinical Orders

ABG+COOX+NA+K+GLU+CA2+ [525948984] — Signed

Entered by:	Results Intf User Utmb 02/29/12 0840	Ordered by:	Gulshan Sharma, MD
Authorized by:	Gulshan Sharma, MD	Frequency:	ONCE 02/29/12 0840 - 1 Occurrences
Electronically signed by:	Results Intf User Utmb 02/29/12 0840		

ACUTE CARE ARTERIAL BLOOD GAS [525943651] — Signed

Entered by:	Results Intf User Utmb 02/29/12 0820	Ordered by:	Gulshan Sharma, MD
Authorized by:	Gulshan Sharma, MD	Frequency:	ONCE 02/29/12 0820 - 1 Occurrences
Electronically signed by:	Results Intf User Utmb 02/29/12 0820		

POCT GLUCOSE (AUTOMATED) [525837771] — Signed

Entered by:	Results Intf User Utmb 02/28/12 1803	Ordered by:	Gulshan Sharma, MD
Authorized by:	Gulshan Sharma, MD	Frequency:	ONCE 02/28/12 1803 - 1 Occurrences
Electronically signed by:	Results Intf User Utmb 02/28/12 1803		

BASIC METABOLIC PANEL (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, CA) [525816521] — Canceled

Entered by:	Jason Bennett Welch, DO 02/28/12 1704	Ordered by:	Jason Bennett Welch, DO
Authorized by:	Jason Bennett Welch, DO	Frequency:	Q4H 02/28/12 2100 - 2 Days
Electronically signed by:	Jason Bennett Welch, DO 02/28/12 1704		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

BASIC METABOLIC PANEL (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, CA) [525816401] — Canceled

Entered by:	Jason Bennett Welch, DO 02/28/12 1704	Ordered by:	Jason Bennett Welch, DO
Authorized by:	Jason Bennett Welch, DO	Frequency:	ONCE 02/28/12 1715 - 1 Occurrences
Electronically signed by:	Jason Bennett Welch, DO 02/28/12 1704		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

POCT GLUCOSE (AUTOMATED) [525716611] — Signed

Entered by:	Results Intf User Utmb 02/28/12 1215	Ordered by:	Gulshan Sharma, MD
Authorized by:	Gulshan Sharma, MD	Frequency:	ONCE 02/28/12 1215 - 1 Occurrences
Electronically signed by:	Results Intf User Utmb 02/28/12 1215		

Acute Care Arterial Blood Gas, [525605661] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0800	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0815 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0800		

FIBRINOGEN [525591841] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0632	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0645 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0632		

D-DIMER [525591851] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0632	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0645 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0632		

FIBRIN DEGRADATION PRODUCTS [525591861] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0632	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0645 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0632		

HEPATIC FUNCTION PANEL (80076) (ALB,T.PRO,BILI T,BU/BC,ALT,AST,ALK PHOS) [525566771] — Canceled

Entered by:	Jennifer L McCracken, MD 02/28/12 0042	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	QAM-0200 02/28/12 0200 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0042		

LAB - Clinical Orders (continued)

HEPATIC FUNCTION PANEL (80076) (ALB,T.PRO,BILI T.BU/BC,ALT,AST,ALK PHOS) [525556777] (continued) — Canceled

Canceled by: Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]

TROPONIN I [525556683] — Canceled

Entered by:	Jennifer L McCracken, MD 02/28/12 0041	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/28/12 0045 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0041		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

CK (CREATINE KINASE) + MB [525556654] — Canceled

Entered by:	Jennifer L McCracken, MD 02/28/12 0041	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/28/12 0045 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0041		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

BLOOD CULTURE [525556405] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0016	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0030 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0016		

BLOOD CULTURE [525556406] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0016	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0030 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0016		

URINE CULTURE [525556407] — Signed

Entered by:	Jennifer L McCracken, MD 02/28/12 0016	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0030 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0016		

LACTIC ACID PLASMA [525556275] — Canceled

Entered by:	Jennifer L McCracken, MD 02/28/12 0006	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/28/12 0015 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0006		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

Magnesium Serum [525549668] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

Prothrombin Time/INR [525549556] — Signed

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		

aPTT [525549557] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 [Condition no longer warrants]		

Acute Care Glucose [525549558] — Signed

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		

Comments:
Notify House Officer (NHO) if Glucose > 140

Basic Metabolic Panel (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, — Canceled

LAB - Clinical Orders (continued)

CA) [526549541

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Jason Bennett Welch, OD 02/28/12 1705 (Duplicate)		

CBC with Differential [525549551 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q8H 02/27/12 2315 - 3 Days
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Haitham T Shaheen, MBBS 02/29/12 1251 (Condition no longer warrants)		

BASIC METABOLIC PANEL (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, CA) [525523301 — Signed

Entered by:	Siva Krishna Mannem, MBBS 02/27/12 2022	Ordered by:	Siva Krishna Mannem, MBBS
Authorized by:	Siva Krishna Mannem, MBBS	Frequency:	ONCE 02/27/12 2030 - 1 Occurrences
Electronically signed by:	Siva Krishna Mannem, MBBS 02/27/12 2022		
Diagnoses:	CARDIAC ARREST (427.5) ALKALOSIS (276.3)		

LACTIC ACID PLASMA [525514601 — Signed

Entered by:	Siva Krishna Mannem, MBBS 02/27/12 1910	Ordered by:	Siva Krishna Mannem, MBBS
Authorized by:	Siva Krishna Mannem, MBBS	Frequency:	ONCE 02/27/12 1915 - 1 Occurrences
Electronically signed by:	Siva Krishna Mannem, MBBS 02/27/12 1910		
Diagnoses:	CARDIAC ARREST (427.5) ALKALOSIS (276.3)		

Acute Care Arterial Blood Gas. [525491701 — Signed

Entered by:	Kevin Michael Dischert, MD 02/27/12 1653	Ordered by:	Kevin Michael Dischert, MD
Authorized by:	Kevin Michael Dischert, MD	Frequency:	ONCE 02/27/12 1700 - 1 Occurrences
Electronically signed by:	Kevin Michael Dischert, MD 02/27/12 1653		
Diagnoses:	CARDIAC ARREST (427.5)		
Questions:	Current Patient Temperature: 34.3 Current FIO2: 100		

LACTIC ACID PLASMA [525424791 — Signed

Entered by:	Results Inif User Utmb 02/27/12 1405	Ordered by:	Marco A de Los Santos, MD
Authorized by:	Marco A de Los Santos, MD	Frequency:	ONCE 02/27/12 1355 - 1 Occurrences
Electronically signed by:	Results Inif User Utmb 02/27/12 1405		

Acute Care Glucose [525411161 — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	Q6H 02/27/12 1330 - 3 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Diagnoses:	CARDIAC ARREST (427.5) ALKALOSIS (276.3)		
Comments:	Notify House Officer (NHO) If Glucose > 140		

LACTIC ACID PLASMA [525399301 — Canceled

Entered by:	Marco A de Los Santos, MD 02/27/12 1244	Ordered by:	Marco A de Los Santos, MD
Authorized by:	Marco A de Los Santos, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Marco A de Los Santos, MD 02/27/12 1244		
Canceled by:	Results Inif User Utmb 02/27/12 1351 (Other)		
Diagnoses:	CARDIAC ARREST (427.5)		

DRUG SCREEN PANEL 2 [525397181 — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST (427.5)		

SALICYLATE, LEVEL [525397191 — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST (427.5)		

LAB - Clinical Orders (continued)

SALICYLATE, LEVEL [525397191] (continued) — Signed

ACETAMINOPHEN, LEVEL [525397201] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

ETHANOL, LEVEL [525397211] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

BASIC METABOLIC PANEL (NA, K, CL, CO2, GLUCOSE, BUN, CREATININE, CA) [525397111] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

URINALYSIS [525397121] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

CBC WITH DIFF [525397131] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

CK (CREATINE KINASE) + MB [525397141] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

TROPONIN I [525397151] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

HEPATIC FUNCTION PANEL (80076) (ALB,T.PRO,BILI T,BU/BC,ALT,AST,ALK PHOS) [525397705] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

Acute Care Arterial Blood Gas. [525397101] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

LIPASE, SERUM [525397041] — Signed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Diagnoses:	CARDIAC ARREST [427.5]		

ABG+COOX+NA+K+GLU+CA2+ [525781361] — Signed

Entered by:	Results Intf User Umb 02/27/12 1230	Ordered by:	Emergency Room
Authorized by:	Emergency Room	Frequency:	ONCE 02/27/12 1230 - 1 Occurrences
Electronically signed	Results Intf User Umb 02/27/12 1230		

LAB - Clinical Orders (continued)

ABG+COOX+NA+K+GLU+CA2+ [5257813 6] (continued) Signed by:

Health

ADMIT ORDER - Clinical Orders

Admit To - MPUMICU [52549288] — Signed

Entered by:	Patricia C Flowers 02/27/12 1659	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1649 - 1 Occurrences
Electronically signed by:	Patricia C Flowers 02/27/12 1659, for Ordering in Bed Reservation mode, Communicator - Patricia C Flowers		
Questions:	Attending: SHARMA, GULSHAN Resident: DOCTOR UNASSIGNED,NO NAME Intern: DOCTOR UNASSIGNED,NO NAME Admit Time: 4:49 PM Service / Team MPUMICU		

Health

MEDS - Clinical Orders

KCL 40 mEq in NaCl 0.9% (NS) piggyback [525912 66] — Completed

Entered by:	Jennifer L McCracken, MD 02/29/12 0424	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/29/12 0430 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/29/12 0424		

NaCl 0.45% (1/2NS) IV infusion [525874731] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/28/12 2302	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/28/12 2315 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 2302		
Canceled by:	Interface Provider Record 02/29/12 2008		

sodium chloride 3 % HYPERTONIC infusion 500 mL [525614450] — Completed

Entered by:	Jennifer L McCracken, MD 02/28/12 0634	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0645 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0634		
Questions:	Central or Peripheral Line?: Central Line		

white petrolatum-mineral oil (LACRI-LUBE S.O.P.) ophthalmic ointment 0.5 inch [525588131] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/28/12 0545	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	PRN 02/28/12 0545 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0545		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	dry eyes		

NaCl 0.9% (NS) IV infusion [5255877 1] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/28/12 0543	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/28/12 0545 - 02/28/12 2302
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0543		
Canceled by:	Jennifer L McCracken, MD 02/28/12 2302		

KCL 40 mEq in NaCl 0.9% (NS) piggyback [525577 06] — Completed

Entered by:	Jennifer L McCracken, MD 02/28/12 0316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0330 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0316		

NOREpinephrine (LEVOPHED) 16 mg in D5W 250 mL infusion [525576191] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/28/12 0251	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	TITRATE 02/28/12 0250 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0251		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	map >90		

pantoprazole (PROTONIX) 40 mg in D5W piggyback [525567951] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/28/12 0055	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q12H 02/28/12 0055 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/28/12 0055		
Canceled by:	Interface Provider Record 02/29/12 2008		

FENTanyl PF (SUBLIMAZE (P/F)) 50 mcg/mL injection 50 mcg [525549741] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	PRN - SEE INSTRUCTIONS 02/27/12 2314 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	Initiation of Analgesia		

FENTanyl PF (SUBLIMAZE (P/F)) 2,500 mcg in NaCl 0.9% (NS) 250 mL infusion [525549751] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	TITRATE 02/27/12 2314 - 02/29/12 2008

MEDS - Clinical Orders (continued)

FENTanyl PF (SUBLIMAZE (P/F)) 2,500 mcg in NaCl 0.9% (NS) 250 mL infusion [52554975] (continued) — Discontinued

Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	Analgesia maintenance		

midazolam (VERSED) injection 2 mg [52554971] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	PRN - SEE INSTRUCTIONS 02/27/12 2314 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	Initiation of Sedation		

midazolam (VERSED) 50 mg in NaCl 0.9% (NS) infusion [52554972] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	TITRATE 02/27/12 2314 - 02/29/12 2008
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Comment:	Maintenance of Sedation		

heparin (porcine) 5,000 unit/0.5 mL injection 5,000 Units [52554938] — Discontinued

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q6H 02/28/12 0600 - 02/28/12 0055
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Jennifer L McCracken, MD 02/28/12 0055 [Condition no longer warrants]		

KCL 40 mEq in NaCl 0.9% (NS) piggyback [52553708] — Completed

Entered by:	Siva Krishna Mannem, MBBS 02/27/12 2158	Ordered by:	Siva Krishna Mannem, MBBS
Authorized by:	Siva Krishna Mannem, MBBS	Frequency:	ONCE 02/27/12 2200 - 1 Occurrences
Electronically signed by:	Siva Krishna Mannem, MBBS 02/27/12 2158		

NaCl 0.9% (NS) IV infusion [52551457] — Discontinued

Entered by:	Siva Krishna Mannem, MBBS 02/27/12 1908	Ordered by:	Siva Krishna Mannem, MBBS
Authorized by:	Siva Krishna Mannem, MBBS	Frequency:	CONTINUOUS 02/27/12 1915 - 02/28/12 0543
Electronically signed by:	Siva Krishna Mannem, MBBS 02/27/12 1908		
Canceled by:	Jennifer L McCracken, MD 02/28/12 0543		

vancomycin 1 g in NS 150 mL (COMPOUNDED) Piggyback 1 g [52549171] — Completed

Entered by:	Kevin Michael Dischert, MD 02/27/12 1653	Ordered by:	Kevin Michael Dischert, MD
Authorized by:	Kevin Michael Dischert, MD	Frequency:	ONCE 02/27/12 1700 - 1 Occurrences
Electronically signed by:	Kevin Michael Dischert, MD 02/27/12 1653		

piperacillin-tazobactam (ZOSYN) 3.375 gram/50 mL Piggyback 3.375 g [52549172] — Completed

Entered by:	Kevin Michael Dischert, MD 02/27/12 1653	Ordered by:	Kevin Michael Dischert, MD
Authorized by:	Kevin Michael Dischert, MD	Frequency:	ONCE 02/27/12 1700 - 1 Occurrences
Electronically signed by:	Kevin Michael Dischert, MD 02/27/12 1653		

LORazepam (ATIVAN) injection 2 mg [52547693] — Completed

Entered by:	Gregory E Rumph, MD 02/27/12 1613	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1615 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1613		

pancuronium (PAVULON) injection 10 mg [52543561] — Completed

Entered by:	Gregory E Rumph, MD 02/27/12 1431	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1445 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1431		

pantoprazole (PROTONIX) 40 mg in D5W piggyback [52541163] — Discontinued

Entered by:	Gregory E Rumph, MD 02/27/12 1331	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	Q24H 02/27/12 1345 - 3 Days
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1331		
Canceled by:	Jennifer L McCracken, MD 02/28/12 0055		

MEDS - Clinical Orders (continued)

sodium bicarbonate 150 mEq in D5W 0.45% NaCl (1/2NS) 1,000 mL IV Solution [52541018] — Discontinued

Entered by:	Gregory E Rumph, MD 02/27/12 1329	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - 6 Hours
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1329		
Canceled by:	Siva Krishna Mannem, MBBS 02/27/12 1908		

NOREpinephrine (LEVOPHED) 4 mg in D5W 250 mL Infusion [52539723] — Discontinued

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1245 - 02/29/12 2008
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Canceled by:	Interface Provider Record 02/29/12 2008		

DOPamine 1.6 mg/ml 800 mg/500 mL (1,600 mcg/mL) Infusion [52539722] — Discontinued

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	TITRATE 02/27/12 1231 - 02/29/12 2008
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Canceled by:	Interface Provider Record 02/29/12 2008		
PRN Reasons:	mBP => 60		

NaCl 0.9% (NS) bolus infusion 1,000 mL [52539708] — Completed

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		

NURSING - Other Orders

Nursing Other - Please actively warm, max of 1 degree per hour. Goal temp of 36 [52582213] — Canceled

Entered by:	Haitham T Shaheen, MBBS 02/28/12 1731	Ordered by:	Haitham T Shaheen, MBBS
Authorized by:	Haitham T Shaheen, MBBS	Frequency:	SEE-COMMENTS 02/28/12 1745 - Until Specified
Electronically signed by:	Haitham T Shaheen, MBBS 02/28/12 1731		
Canceled by:	Interface Provider Record 02/29/12 2009		
Comments:	Please actively warm, max of 1 degree per hour. Goal temp of 36		

Nursing Other - Begin passive rewarming. NHO at temp of 36C [52562765] — Canceled

Entered by:	Jason Bennett Welch, DO 02/28/12 0913	Ordered by:	Jason Bennett Welch, DO
Authorized by:	Jason Bennett Welch, DO	Frequency:	SEE-COMMENTS 02/28/12 0915 - Until Specified
Electronically signed by:	Jason Bennett Welch, DO 02/28/12 0913		
Canceled by:	Haitham T Shaheen, MBBS 02/28/12 1731 [Condition no longer warrants]		
Comments:	Begin passive rewarming. NHO at temp of 36C		

Pain scale assessment and record. Assess and document pain. If patient denies pain, wean patient off analgesia. [52554973] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q2H 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Daily interruption of sedation/analgesia [52554976] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		
Comments:	Daily interruption of sedation/analgesia will begin 48 hrs after intubation at 6:00 AM unless otherwise ordered. Hold all sedation and reduce rate of analgesic to half the previous rate. If patient becomes agitated, notify house officer, and bolus with Midazolam 2 mg SIVP every 15 minutes for 2 doses as needed and Fentanyl 50 mcg SIVP every 15 minutes for 2 doses as needed. Also, resume the analgesia infusion (Fentanyl) at the previous rate and the sedation infusion (Lorazepam) at half the previous rate.		

RASS Assessment and record [52554970] — Canceled

NURSING - Other Orders (continued)

RASS Assessment and record [52554970] (continued) — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q2H 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Induced Hypothermia: Initiate Hypothermia and set goal temperature to 32 degrees Celsius. [52554963] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Comments:
Utilize additional cooling measures if patient not reaching goal temperature over 8 hours (i.e. ice packs, cooling blanket). Maintain temperature at 32 degrees Celsius for 24 hours after goal temperature reached. Begin rewarming 24 hours after goal temperature of 32 degrees Celsius achieved. Turn off cooling device and allow passive rewarming, keeping cooling pads on patient. If temperature increases > 1 degree Celsius per hour, reapply cooling device at a higher temperature to slow rewarming.

Induced Hypothermia: Maintain sedation/analgesia and paralytic (if initiated) until normothermia (36 degrees Celsius) is achieved. [52554964] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Comments:
Once normothermia is achieved, discontinue paralytic infusion (when applicable). Discontinue sedation/analgesia once TOF (Train-of-four) 4/4 is achieved.

Physican indicated target RASS score [52554969] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Comments:
Target RASS score: - 4

Activity: Head of bed at 30 degrees at all times; Avoid any motion during hypothermia (i.e. CXR, Turning of patient) to avoid cardiac arrhythmias. [52554959] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Vital Signs Q1H during hypothermia [52554960] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Induced Hypothermia Notify House Officer (NHO) Parameters [52554961] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Comments:
For MAP < 90, significant dysrhythmias, hemodynamic instability, active bleeding, presence of shivering, and/or blood glucose > 140. If shivering occurs, NHO for orders to initiate neuromuscular blockade (once complete sedation and ventilatory support is achieved).

Induced Hypothermia: Initiate Sedation and Analgesia order sets. Titrate to (Richmond Agitation Sedation Scale) RASS -4 for duration of hypothermia. [52554962] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Wedge cushion, CRITERIA: Patient with LOS (or projected LOS) => 24 — Canceled

NURSING - Other Orders (continued)

hours and a Braden Mobility Score <= 2 (1 per patient) [525549491

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Head of bed at 30 degrees at all times [525549501 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Cath placement - Foley to gravity drainage with Temperature probe [525549511 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		
Question:	Reason Hemodynamically unstable needing accurate intake and output		

Line placements: Arterial line [525549521 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Assess skin integrity Q1-2H [525549531 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Turn patient [525549411 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q2H 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Keep bed linens clean, dry, and wrinkle free [525549421 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Use pillows between knees and boney prominences to avoid direct contact [525549431 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Minimum of 2 people and draw sheet to move immobile patient up in bed [525549441 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Lights on during the day [525549451 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Attempt to not wake, or minimal stimulation, between 22:00 and 06:00 [525549461 — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD

NURSING - Other Orders (continued)

Attempt to not wake, or minimal stimulation, between 22:00 and 06:00 [52554946] (continued) — Canceled

Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Clean / protect skin with Comfort Shield to prevent skin breakdown after each incontinent episode [52554947] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Relieve pressure, friction, shear and/or moisture [52554948] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Strict Intake and Output Measurement, and Record [52554934] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q2H 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Continuous Cardiac Monitoring (Other Than Telemetry) [52554935] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Pulse Oximetry by Nursing [52554936] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

TED Hose (Knee Hi) with Removal and Notify House Officer (NHO) Parameters [52554937] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Questions:
Remove TED Hose BID for 30 Minutes: Yes
NHO for evidence of pressure ulcers or complaints of persistent numbness or tingling Yes
May DC TED Hose when patient is ambulatory and OOB > 50% of the time: Yes

Notify House Officer (NHO) Parameters [52554938] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	SEE-COMMENTS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2009		

Questions:
Systolic Blood Pressure: > 160 < 100
Diastolic Blood Pressure: > 110 < 50
Pulse: > 120 < 60
Glucose: > 180
Urine Output: < 30 ML/H
Chest Pain: YES
Temperature: => 38.5 C
Respiratory Rate: > 30 < 10
Shortness of Breath: YES

Comments:
MICU / CCU Admission Order Set

If admission orders placed at a held status, please release on patient's arrival to floor/unit [52554929] — Signed

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/27/12 2315 - 1 Occurrences
Electronically signed	Jennifer L McCracken, MD 02/27/12 2316		

NURSING - Other Orders (continued)

If admission orders placed at a held status, please release on patient's arrival to floor/unit [52554929] (continued) — Signed

by:

Patient height on admission [52554930] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/27/12 2315 - 1 Occurrences
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		

Patient Weight [52554931] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	QDAILY 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		

Comments:
First weight on admission.

Activity: Bedrest [52554932] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	CONTINUOUS 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		

Vital Signs [52554933] — Canceled

Entered by:	Jennifer L McCracken, MD 02/27/12 2316	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	Q2H 02/27/12 2315 - Until Specified
Electronically signed by:	Jennifer L McCracken, MD 02/27/12 2316		
Canceled by:	Interface Provider Record 02/29/12 2008		

Comments:
Includes blood pressure, heart rate, respiratory rate, body temperature, O2 saturations and pain. CORE temperature preferred.

Induced Hypothermia: Initiate Sedation and Analgesia order sets. Titrate to (Richmond Agitation Sedation Scale) RASS -4 for duration of hypothermia. [52541120] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Induced Hypothermia: Initiate Hypothermia and set goal temperature to 32 degrees Celsius. [52541121] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	SEE-COMMENTS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Comments:
Utilize additional cooling measures if patient not reaching goal temperature over 6 hours (i.e. ice packs, cooling blanket). Maintain temperature at 32 degrees Celsius for 24 hours after goal temperature reached. Begin rewarming 24 hours after goal temperature of 32 degrees Celsius achieved. Turn off cooling device and allow passive rewarming, keeping cooling pads on patient. If temperature increases > 1 degree Celsius per hour, reapply cooling device at a higher temperature to slow rewarming.

Induced Hypothermia: Maintain sedation/analgesia and paralytic (if initiated) until normothermia (36 degrees Celsius) is achieved. [52541123] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	SEE-COMMENTS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Comments:
Once normothermia is achieved, discontinue paralytic infusion (when applicable). Discontinue sedation/analgesia once TOF (Train-of-four) 4/4 is achieved.

Tube Placement: Nasogastric - To Low Intermittent Wall Suction (LIWS) [52541124] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		
Questions:	Parameter To Low Intermittent Wall Suction (LIWS)		

NURSING - Other Orders (continued)

Line placements: Arterial line [525411113] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Assess skin integrity Q1-2H [525411114] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Activity: Head of bed at 30 degrees at all times; Avoid any motion during hypothermia (i.e. CXR, Turning of patient) to avoid cardiac arrhythmias. [525411116] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Vital Signs Q1H during hypothermia [525411118] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Induced Hypothermia Notify House Officer (NHO) Parameters [525411119] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1330	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	SEE-COMMENTS 02/27/12 1330 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1330		
Canceled by:	Interface Provider Record 02/29/12 2008		

Comments:
For MAP < 90, significant dysrhythmias, hemodynamic instability, active bleeding, presence of shivering, and/or blood glucose > 140. If shivering occurs, NHO for orders to initiate neuromuscular blockade (once complete sedation and ventilatory support is achieved).

CATH PLACEMENT - FOLEY TO GRAVITY DRAINAGE [525397145] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1245 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Canceled by:	Interface Provider Record 02/29/12 2008		
Questions:	Reason Hemodynamically unstable needing accurate intake and output		

CONTINUOUS CARDIAC MONITORING-ED [525397161] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	CONTINUOUS 02/27/12 1245 - Until Specified
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Canceled by:	Interface Provider Record 02/29/12 2008		

LINE PLACEMENTS: PERIPHERAL IV [525397171] — Canceled

Entered by:	Gregory E Rumph, MD 02/27/12 1233	Ordered by:	Gregory E Rumph, MD
Authorized by:	Gregory E Rumph, MD	Frequency:	ONCE 02/27/12 1245 - 1 Occurrences
Electronically signed by:	Gregory E Rumph, MD 02/27/12 1233		
Canceled by:	Interface Provider Record 02/29/12 2008		

CONSULT - Other Orders

Consult PS Pastoral Care [525566536] — Signed

Entered by:	Michael M Gold, RN 02/28/12 0031	Ordered by:	Jennifer L McCracken, MD
Authorized by:	Jennifer L McCracken, MD	Frequency:	ONCE 02/28/12 0045 - 1 Occurrences
Electronically signed by:	Michael M Gold, RN 02/28/12 0031, for Ordering in Positive Screen Consult mode, Communicator - Michael M Gold, RN		
Questions:	Religious preference: Baptist		

Comments:
Screening Information: Hospital stay may affect spiritual and/or cultural practices and/or beliefs: No Help needed to maintain spiritual and/or cultural strength: None

Consult PS Food and Nutrition - Adult [525566502] — Signed

Entered by:	Michael M Gold, RN 02/28/12 0028	Ordered by:	Jennifer L McCracken, MD